Jackson HEALTH SYSTEM

PUBLIC HEALTH TRUST

JMH Health Plan

GROUP MEDICAL AND HOSPITAL SERVICE CONTRACT

CERTIFICATE OF COVERAGE

HMO

TABLE OF CONTENTS

WHAT YOU SHOULD KNOW ABOUT THE HEALTH PLAN

1. The JMH Health Plan offers a broad network of primary care physicians, specialists, and health care providers throughout South Florida to meet all the health care needs of our members.

2. As a member, you must choose a Primary Care Physician (PCP) for yourself and your dependents, if any, on the date of enrollment. If you do not choose a Primary Care Physician, we will assign one to you and notify you of the assignment.

3. If for any reason you become dissatisfied with your assigned primary care physician and/or service location, you may request reassignment at anytime by notifying our Member Services Department at **(305) 575-3640**. The effective date of the change will be the first day of the following month.

4. Your Primary Care Physician will oversee your health care services. Your physician will coordinate consultations to medical specialists and other providers as you require. You may select or change to any specialist from the list of JMH Health Plan providers.

5. A Plan Physician may be contacted twenty-four (24) hours a day, seven (7) days a week. Call your Primary Care Physician at the telephone number listed on your member ID card.

6. Outpatient medical services are available through your Primary Care Physician or through consultations with one of the Plan's many in-network providers. Inpatient medical services are provided by our network of affiliated hospitals, including Jackson Memorial Hospital.

7. You have the right to a second medical opinion. Please call our Member Services Department **(305) 575-3640** for assistance.

8. Our Member Services Department is available to assist you with any questions and/or problems you may have.

9. Emergency Care is provided at Jackson Memorial Hospital, or at any other affiliated hospital. In case of an emergency medical condition, you should seek services at the nearest emergency room.

10. According to Florida Statute 641.3154, providers are prohibited from billing enrollees of HMO's for covered services. When a provider bills you for any covered services you may forward a copy of the bill or invoice to our Member Services Department or call our Member Services Department at **305-575-3640** for assistance.

11. If you would like information regarding a provider's credentials or information regarding the absence of malpractice insurance, you may call our Member Services Department **(305) 575-3640** for assistance.

12. You may obtain information regarding performance outcomes and financial data for the Health Plan published by the State of Florida Agency for Health Care Administration by accessing the Health Plan's website www.jmhhp.com. This website includes the link to FloridaHealthStat where this information is published.

MEMBER'S RIGHTS AND RESPONSIBILITIES

RIGHTS

As a valued member of the JMH Health Plan and its governing body, the Public Health Trust of Miami-Dade County, FL; the following are your rights and responsibilities.

Access to Care

You have the right to impartial access to medically indicated treatment or accommodations, regardless of race, national origin, religion, disability or source of payment.

When the Health Plan cannot meet your request or need for care, you will be transferred when medically permissible to an available and appropriate facility.

You have the right to express your wishes with regard to your medical care. The Health Plan is willing to honor lawful requests to withhold or withdraw treatment should you or your legal representative decide to do so.

You have the right to appropriate assessment and management of your pain and to be involved in decisions about managing your pain.

Respect, Dignity and Consideration

You have the right to considerate, respectful care at all times and under all circumstances, with recognition of your personal dignity, psychosocial needs, cultural, spiritual, personal values and belief systems.

You have the right to exercise your cultural and spiritual beliefs that do not interfere with the well-being of others or your planned course of medical therapy.

You have the right to know what patient support services are available, including whether an interpreter is available if you do not speak English.

Privacy and Confidentiality

You have the right, within the limits of the law, to personal privacy and confidentiality of information.

You do not have to speak with people who are not directly involved in your care.

Your discussions with your doctor should not be shared without your permission.

When you are examined, you are entitled to have the curtains drawn and to know what role any observer may have in your care.

You or your legal representative has the right to access the information contained in your medical record as allowed by the law. Your medical record should only be read by individuals monitoring your care or by individuals authorized by the law or regulation. Your medical record will be restricted as above unless you or your legal representative has given written authorization to someone else.

Clear Information About Your Condition and Care

You or your legal representative have the right to necessary information, with a clear and concise explanation, to enable you to make treatment decisions that reflect your wishes. You should not be subjected to any medical procedure posing risks without your understanding and consent (or that of your legal representative).

You have the right to know of experimental, research, or educational activities involved in your treatment. You also have the right to refuse to participate in any such activity.

Involvement in Decision Making

You or your legal representative have the right, in collaboration with your physician, to make decisions involving your care:

- the identity of the physician who has primary responsibility for your care;
- the identity and professional status of the individuals who are authorizing and performing the procedure;
- the existence of any multidisciplinary professional relationships among the individuals treating you;
- the nature and purpose of the treatment or procedure;
- the potential benefit(s) of the treatment or procedure;
- the potential drawbacks(s) of the treatment or procedure;
- the likelihood of success of the treatment or procedure;
- problems related to recuperation; and,
- any significant alternatives to the treatment or procedure.

Documentation in the medical record will reflect that this information has been provided to you.

You have the right to formulate advance directives.

You or your legal representative have the right to participate in the consideration of ethical issues that arise in your care.

Names of Your Caregivers

You have a right to know the identity and professional status of all the people involved in your care, including the identity of the physician who is primarily responsible for your treatment.

Refusal of Treatment

You have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal. You have the right to refuse treatment against medical advice, but you will be asked to sign a form to that effect.

Communication

You have the right to contact people outside the Health Plan by means of written or verbal communication. You also have the right to an interpreter, if necessary.

Plan Rules and Regulations

You have the right to know what Health Plan rules and regulations apply to you as a patient. If you have any complaints, you have a right to access the Health Plan's system of answering member complaints. Your complaint will in no way affect the quality of care or compromise your future access to care.

RESPONSIBILITIES

As a member of the Health Plan, you also have certain responsibilities which are for your own best interests.

Provide Information

You are responsible for providing, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, advance directives, and other matters relating to your health or care.

You are responsible for reporting whether you clearly understand a planned course of action and what is expected of you.

Follow Instructions

You are responsible for following the treatment plan recommended by your caregivers. If you do not understand any instructions or if you have concerns, you need to let your caregiver know immediately about your misgivings.

Keep Appointments

You should keep any and all appointments or telephone the provider if you cannot keep the appointment.

Refusal of Treatment

If you refuse treatment or do not follow medical instructions, you are responsible for your own actions.

Respect for Others

You are responsible for being considerate of other patients, and Plan personnel and property.

Plan Rules and Regulations

You are responsible for following the Plan's rules and regulations that affect patient care and conduct.

ADMINISTRATIVE PROVISIONS

This section provides important information on the administration of the Health Plan, explaining:

1. Who is eligible for benefits under this Health Plan, when coverage becomes effective, when coverage terminates, and what the covered person can do to continue coverage or convert to other coverage;

2. How this Health Plan shall relate to other plans under which covered persons have coverage or other situations where payment is made for the services covered under this Health Plan; and

3. How the covered person can appeal to the Health Plan on benefit decisions.

ELIGIBILITY AND EFFECTIVE DATES

Because this coverage is group coverage, eligibility for coverage is tied to the individual's relationship with the Subscribing Group. In addition, the individual must reside or work within the Health Plan's service area and be able to access health care services within the Health Plan's service area. The following sections explain eligibility and effective dates of this coverage.

ELIGIBILITY UNDER THIS GROUP PLAN

To be eligible for coverage under this Group Plan, an individual must be either:

1. An **employee** of the Subscribing Group who a) works the required number of hours per week from a worksite located within the Service Area as set forth in the Master Employer Application; and b) is employed for the period of time required for eligibility as set forth in the Master Employer Application, and c) either resides in the Service Area or in a county contiguous to the Service Area.

2. A **retiree under age 65**, which means any full-time, regular employee under 65 who retires with the required number of years of active service as determined by the Subscribing Group, and who has applied for pension benefits, may continue membership for themselves and their dependents until age 65 with remittance of the required premium to the employer, if coverage is made available by the employer.

3. A **retiree 65 or over** which means any full-time regular employee of the Subscribing Group who retires and who has applied for pension benefits may continue membership for themselves and their dependents with remittance of the required premium to the employer, if coverage is made available by the employer.

4. **Retiring employees** shall have a one-time opportunity at the time of retirement, but no later than 30 days from the retirement date, to change their medical plan election in order to allow participation in the option which best meets their retirement needs, if coverage is made available by the employer.

5. A **dependent,** which means the following:

    a. The wife or husband of the employee and any eligible children;

    b. The wife or husband of the retiree and any eligible children;

    c. The Domestic Partner of the employee and any eligible children if covered by the Subscriber's Group Plan and as defined by the Group Plan.

    d. The Domestic Partner of the retiree and any eligible children if covered by the Subscriber's Group Plan and as defined by the Group Plan.

e. The eligible children of a surviving spouse; and

f. The newborn children of an eligible child. Coverage for such newborn children shall terminate 18 months after the birth of the newborn children.

6. A **child**, which means the employee's unmarried own child, adopted child or child placed in the employee's home for the purpose of adoption in accordance with chapter 63, Florida Statutes, a step-child who the employee can claim as an exemption on his or her federal income tax return, a child for whom legal guardianship has been established pursuant to chapter 744, Florida Statutes, a foster child, or any other unmarried child for whom the employee has been granted court ordered permanent custody. The child must be chiefly dependent upon the subscriber for support and living in the household of the subscriber or the subscriber's legally separated spouse. Such children shall be eligible for coverage as follows:

   a. From their date of birth to the end of the calendar year in which their 19th birthday occurs;

   b. From end of the calendar year in which their 19th birthday occurs until the end of the calendar year in which their 25th birthday occurs, if the eligible employee, or surviving spouse can claim such children as an exemption on his or her federal income tax return and such children are either living with the eligible employee or surviving spouse or are enrolled in any school, college, or university which provides training or educational activities and which is certified or licensed by a state or foreign country;

   c. Children who are mentally or physically disabled shall be eligible after attainment of the above age limits and while the employee's or retiree's dependent coverage is in effect provided that such children are incapable of self-sustaining employment by reason of such mental or physical handicap, are chiefly dependent upon the employee or surviving spouse for support and maintenance, and coverage commenced prior to age 25; or

   d. When an eligible child marries, all coverage shall cease for that child on the date which the marriage occurs.

   e. Dependent children from the age of 25 to the end of the calendar in which their 30th birthday occurs if the child meets the following conditions: 1) the child is unmarried and does not have any dependents of his/her own; 2) the child is a resident of the state of Florida or a full/part-time student; 3) the child is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVlll of the Social Security Act.

      If a dependent child is provided coverage under the Subscriber's Certificate of Coverage after the child reaches age twenty-five (25) and the coverage for the child is subsequently terminated prior to the end of the Calendar Year in which the child turns age thirty (30), the child is ineligible to be covered again under the Member's Certificate of Coverage unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.

The subscriber upon request shall provide legal documentation for proof of dependency such as a birth or marriage certificate or income tax return. In addition, the Health Plan shall be responsible for: (1) requesting, verifying and maintaining documentation for eligible children who reach the maximum age requirements to determine school enrollment or handicap status; (2) when a determination is made that a child is no longer eligible as a dependent, notifying the member, in writing, that they have 30 days from the date of the letter to notify their personnel office and the Health Plan of this change. If the documentation is not received within 30 days, the Plan may disenroll the child who is no longer eligible as a dependent from group coverage. Dependent children losing group coverage due to age shall be notified of their COBRA rights.

ENROLLMENT PERIODS

There are three types of time periods for coverage enrollment under this Health Plan:

1. The **initial enrollment period** is the period of time during which an employee is first eligible to enroll and begins on the employee's initial date of employment and ends 30 days later.

2. The **annual open enrollment period** is the period of time designated each calendar year during which: 1) eligible employees may enroll in the Health Plan or, 2) eligible employees, retirees, surviving spouses or COBRA participants may transfer from their present plan to any other plan available without application of waiting periods or exclusions based on health status as conditions of enrollment or transfer.

3. A **special enrollment period** is the period of time during which eligible employees, surviving spouses, and COBRA participants may enroll. Eligible employees who are not enrolled for coverage under the terms of this contract, or a dependent of such an employee if the dependent is eligible but not enrolled for coverage under such terms, shall be allowed to enroll for coverage under the terms of the contract if each of the following conditions is met:

    a. The Employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Employee or dependent;

    b. The Employee or dependent's coverage described in the first paragraph:

        1. Was under a COBRA continuation provision or continuation pursuant to s.627.6692, and the coverage under such provision was exhausted; or

        2. Was not under such a provision and the coverage was terminated as a result of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of employer contributions toward such coverage.

    c. Under the terms of the contract, the Employee requests such enrollment not later than 30 days after the date of exhaustion of coverage as described in subparagraph b) 1; or termination of employment or termination of employer contribution described in subparagraphs b) 2.

    The Health Plan shall provide a dependent special enrollment period during which the person may be enrolled under the plan as a dependent of the Employee as in the case of a person who becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, or the spouse of the Employee may be enrolled as a dependent of the Employee if such spouse is otherwise eligible for coverage. The Employee may enroll at this time as well, if not already enrolled.

    a. A dependent special enrollment period shall be a period of not less than 30 days and shall begin on the later of:

        1. The date dependent coverage is made available; or

        2. The date of the marriage, birth, or adoption or placement for adoption described in the above paragraph.

    b. If an Employee seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

1. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.

2. In the case of a newborn dependent's birth, as of the date of such birth.

3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

4. **A late enrollment period** is for an Eligible Employee or Eligible Dependent who does not enroll under this Group Plan during his or her Initial Enrollment Period will be considered a Late Enrollee, unless he or she qualifies and enrolls under the Special Enrollment Period.

   Unless otherwise prohibited by law, Late Enrollees who want to enroll for coverage under this Group Plan must wait until the next Annual Open Enrollment Period.

EMPLOYEE ENROLLMENT

Eligible employees who become insured under this Health Plan shall be included in the definition of "covered persons." To become a covered person, the employee shall:

1. Complete and submit, through his or her employing agency, a written request for coverage, using enrollment forms provided and approved by both the Health Plan and the Subscribing Group; and

2. Agree to pay his or her portion of the required premium, if required by the Subscribing Group.

An employee who is a newly eligible employee shall enroll within the initial enrollment period. An employee, surviving spouse or COBRA participant who has been covered under another health benefit plan established and maintained by the Subscribing Group, and who now wants to change to this Health Plan, shall enroll for such coverage change during an annual open enrollment period or special enrollment period.

EMPLOYEE EFFECTIVE DATE

The effective date of coverage for enrollment in this Health Plan shall be the first day of the month after the month in which a full month's premium has been received by the Plan.

DEPENDENT EFFECTIVE DATE

The effective date of a dependent's coverage under this Health Plan depends on when the dependent is enrolled:

1. If the dependent is eligible for coverage on the group effective date, coverage for the dependent shall become effective on the group effective date if the employee enrolls the dependent for coverage at the same time he or she enrolls during the initial enrollment period.

2. If the employee through whom the dependent is eligible first becomes eligible after the group effective date and the employee enrolls himself or herself and his or her dependents during the initial enrollment period, coverage for the dependents shall be effective on the same date that the employee's coverage becomes effective.

3. The effective date of coverage for a dependent of a covered employee shall be the date of birth or acquisition when:

   a. the covered employee has family coverage;

   b. the dependent becomes eligible after the covered employee’s effective date; and

c. the covered employee enrolls the dependent within 31 days after eligibility as a dependent begins.

4. The effective date of coverage for a dependent of a covered employee enrolled in individual coverage shall be:

   a. the date of birth or acquisition; and

   b. the first day of the month after the month in which a full month's premium for family coverage has been received by the Plan.

If, on the date dependent coverage becomes effective, the dependent is covered for a condition under an extension of group health benefits from previous employer-related health plan, health insurance plan, or other coverage arrangement, coverage under this health plan, for extension related services or supplies for that condition, shall not begin until the extension under the prior plan ends.

PRE-EXISTING CONDITION LIMITATIONS

Pre-existing condition limitations do not apply to this contract.

COVERAGE FOR NEWBORN CHILDREN

All health coverage applicable for children under this Health Plan will be provided for the newborn child of the Covered Employee or to a Covered Dependent from the moment of birth if the Covered Employee has dependent coverage. However, with respect to the newborn child of a Covered Dependent of the Covered Employee other than the Covered Employee's spouse, the coverage for a newborn child terminates eighteen (18) months after the newborn's birth.

The coverage for newborn children shall consist of coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities, or prematurity, and the transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending physician as necessary to protect the health and safety of the newborn child. The coverage for transportation costs may not exceed allowed charges of $1,000.

Newborn coverage shall take effect at the moment of birth and will continue for thirty (30) days if the Plan is notified by the Covered Person to enroll the child. If timely notice is given, no Premium will be charged for the first thirty (30) days. If the Covered Person fails to enroll the child within thirty (30) days of birth, but enrolls the child within sixty (60) days of birth, the Covered Person will be required to pay an additional Premium from the date of birth. If notice is given within sixty (60) days, the Plan will not deny coverage due to the failure of the Covered Employee to timely notify the Plan of the birth. If notice of the birth is not given within sixty (60) days of birth, the newborn child will be considered a Late Enrollee and will not be eligible to enroll for coverage until the next Annual Open Enrollment Period (See Late Enrollee provision). A newborn child of a covered dependent child is covered for a period of eighteen (18) months if the child is enrolled as specified herein.

COVERAGE FOR ADOPTED CHILDREN

All health coverage applicable for children under this Health Plan will be provided for the adopted child of the Covered Employee if the Covered Employee has dependent coverage. Coverage is provided to a child the Covered Employee proposes to adopt who is placed in the Covered Employee's residence in compliance with chapter 63, from the moment of placement. A newborn infant who is adopted by the Covered Employee is covered from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event the child is not ultimately placed in Your residence in compliance with chapter 63.

The Covered Employee's adopted child is covered from the moment of placement in the residence, or if a newborn, from the moment of birth, if the child is enrolled as specified herein. If the Covered Employee notifies the Plan to enroll the child within thirty (30) days from the moment of birth or placement, a Premium will not be charged for the first thirty (30) days. If the Covered Employee fails to enroll the child within thirty (30) days of the event, but enrolls the child within sixty (60) days of the event, the Covered Employee will be required to pay an additional Premium from the date of birth or placement. If notice is given within sixty 60) days of the event, the Plan will not deny coverage due to the failure of the Covered Employee to timely notify Us of the adoption. Notice of the birth or placement after sixty (60) days will be considered a Late Enrollment and subject to the delayed coverage rules specified in the Late Enrollee provision.

COVERAGE FOR FOSTER CHILDREN

Coverage for a foster child or a child otherwise placed in the covered person's custody by a court order shall be provided from the date of placement if on the date of placement the covered person has family coverage. However, covered persons with individual coverage shall convert to family coverage prior to the placement of the foster child. If the foster newborn child is born prior to the conversion to family coverage, only well-baby hospital nursery services shall be eligible for coverage. Covered services for the foster child shall be the same as any other dependent child. No coverage shall be provided under this provision for the child who is not ultimately placed in the covered person's home. For children in the covered person's custody, coverage shall terminate the date the covered person no longer has legal custody.

TERMINATION OF GROUP COVERAGE

Because this plan provides group coverage, the continuation of the coverage depends on the decisions of the Employer and on the Covered Employee's continued employment relationship to the Employer. The following sections explain when coverage will end, and the options available to the Covered Person to continue or convert coverage.

TERMINATION OF EMPLOYEE COVERAGE

A Covered Employee's coverage under this Group Plan will end automatically at 12:01 a.m., local standard time, on the date:

1. The contract between the Employer and the Plan ends.

2. The Employer fails to pay the Premium due, or the Covered Employee otherwise fails to continue to meet each of the eligibility requirements under this Group Plan.

3. The Covered Employee becomes covered under another health benefit plan which is established and maintained through or in connection with the Employer as an alternative to this Group Plan.

4. The Covered Employee's coverage is terminated for cause (See the Termination of Individual Coverage provision below).

TERMINATION OF A DEPENDENT'S COVERAGE

A Covered Dependent's coverage under this Group Plan will end automatically at 12:01 a.m., local standard time, on the date:

1. The contract between the Employer and the Plan ends.

2. The Covered Employee's coverage terminates for any reason.

3. The Covered Dependent otherwise fails to continue to meet each of the eligibility requirements under this Group Plan.

4. The Covered Dependent becomes covered under another health benefit plan which is offered through or in connection with the Employer as an alternative to this Group Plan.

5. The Covered Dependent's coverage is terminated for cause (see the Termination of Individual Coverage provision below).

TERMINATION OF AN INDIVIDUAL'S COVERAGE

1. Unless otherwise prohibited by law, if in the Plan's opinion any of the following events occur, the Plan may terminate a Covered Person's coverage as specified below:

    a. The date specified by the Plan due to the Covered Person's disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that such Covered Person's continued Membership in the Group Plan, impairs Our ability to provide coverage and/or benefits or to arrange for the delivery of health care services to such Covered Person or to other Covered Persons. Prior to disenrolling a Covered Person for any of the above reasons, the Plan will:

        1) Make a reasonable effort to resolve the problem presented by the Covered Person, including the use or attempted use of the Plan's Grievance Procedure; and

        2) To the extent possible, ascertain that the Covered Person's behavior is not related to the use of medical services or mental illness; and

        3) Document the problems encountered, efforts made to resolve the problems, and any of the Covered Person's medical conditions involved.

    b. The date specified by the Plan that all coverage will terminate due to: (1) fraud or material misrepresentation in applying for or presenting any claim for benefits under this Group Plan; or (2) permitting the use of his or her Covered Membership Card by any other person or (3) furnishing of false or incomplete information on the enrollment forms, or other forms completed for the Plan, by or on behalf of the Covered Person for the purpose of fraudulently obtaining coverage. False, material information includes, but is not limited to information relating to residence and/or employment, information relating to another person's eligibility for coverage or status as a Dependent. the Plan has the right to rescind coverage back to the effective date, in accordance with s. 641.31(23), Florida Statutes, Time Limit on Certain Defenses.

    c. The date specified by the Plan if the Covered Person leaves the Plan's Service Area with the intention to relocate or establish a new residence.

    d. The date specified by the Plan if a Covered Dependent reaches the limiting age as specified in the Eligibility Section of this Group Plan or if a court order, including a qualified medical child support order, covering a dependent child is no longer in effect.

2. Any termination made under these provisions is subject to review in accordance with the Grievance Procedure described herein.

NOTE: "Time Limit on Certain Defenses", Relative to a misstatement in the application, after two (2) years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the two (2) year period.

HANDICAPPED CHILDREN COVERAGE TERMINATION

If a child attains the limiting age for a covered dependent, coverage shall not terminate while that person is, and continues to be, both:

1. Incapable of self-sustaining employment by reason of mental or physical disability; and

2. Chiefly dependent on the covered person for support and maintenance.

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage, the covered person shall have the burden of establishing that the child is and has continued to be handicapped.

The coverage of the handicapped child may be continued, but not beyond the termination date of such incapacity or such dependence. This provision shall in no event limit the application of any other provision of this Health Plan terminating such child's coverage for any other reason than the attainment of the limiting age.

CERTIFICATE OF CREDITABLE COVERAGE

Within thirty (30) days of a Covered Person's last date of coverage with the Plan, a Certificate of Creditable Coverage will be mailed to the Covered Person's home. This Certificate will indicate the period of time the Covered Person was enrolled with the Plan and provides evidence of a Covered Person's coverage with the Plan that may be needed when applying for health coverage in the future.

RIGHTS TO EXTENSION, CONVERSION, AND CONTINUATION

If coverage for a Covered Employee or a Covered Dependent ends, that Covered Person may, depending on his or her situation, have the right to have coverage extended under the Extension of Benefits provision. In addition, coverage may be continued under the Federal Continuation of Coverage (COBRA) provision or Florida Continuation of Coverage provision. Finally, the Covered Person may be eligible for an alternative coverage plan under the Conversion Privilege provision.

EXTENSION OF BENEFITS

In the event this Group Plan is terminated for any reason and a Covered Person is totally disabled, the benefits described in the Covered Services section will be payable, subject to the regular benefit limits described in the Covered Services section, for expenses incurred due to the sickness or injury which caused such continuous total disability. This extension of benefits will cease on the earliest of:

1. The date on which the continuous total disability ceases;

2. The end of the twelve (12) month period immediately following the termination date of the Group Plan.

3. For pregnancy, maternity benefits will continue until the date of delivery, provided the pregnancy began after the Covered Person's effective date and prior to the termination of the Group Plan. This extension will not be based on total disability; or

For the purposes of this section, "continuous total disability" and "totally disabled" mean:

1. For the Covered Employee, the inability to perform any work or occupation for which the Covered Employee is reasonably qualified or trained.

2. For any other Covered Person, the inability to engage in most normal activities of a person of like age and sex in good health.

A Covered Person is not entitled to extension of benefits if coverage is terminated for any of the following reasons:

1. For cause, due to disruptive, unruly, abusive, or uncooperative behavior to the extent that such Covered Person's continued Membership in the Group Plan impairs Our ability to administer this Plan or to arrange for the delivery of health care services to such Covered Persons;

2. Fraud or intentional misrepresentation or omission in applying for any benefits under this Group Plan; or

3. The Covered Person has left the Plan's Service Area with the intent to relocate or establish a new residence.

FEDERAL CONTINUATION PROVISIONS

There is a federal law which permits Covered Persons to continue coverage under an employer established health benefit plan under certain circumstances. This law is referred to as COBRA, which stands for "the Consolidated Omnibus Budget Reconciliation Act of 1986" and any amendments thereto. This continuation provision applies only to an employer of 20 or more employees. Covered Persons should check with the Employer regarding the availability of this option.

It is the Employer's responsibility to make employees aware of any COBRA rights they may have, if the employer is subject to COBRA. Information on employee COBRA rights may also be obtained from the United States Department of Labor.

THE CONVERSION PRIVILEGE

A Covered Employee, who has been continuously covered for at least three months under this Group Plan and/or under another group plan providing similar benefits, in effect, immediately prior to this Group Plan, has the right to apply for a conversion plan if coverage terminates due to the Covered Employee's:

1. Termination of employment;

2. Termination of Covered Employee's Covered Membership in an eligible class;

3. Loss of coverage due to the termination of this Group Plan, if it is not replaced by another health care plan within 31 days of termination.

A Covered Employee's dependents who are covered as dependents under this Group Plan may also convert, but only as dependents of the Covered Employee, not on their own.

However, when a Covered Employee's dependents have been covered for 3 consecutive months before coverage ends, they may, on their own, convert to a conversion plan under one of these following conditions:

1. If the Covered Employee's conversion coverage terminates, Covered Dependents may convert as dependents under a new conversion plan.

2. If the Covered Employee dies, the covered spouse may convert.

3. If the Covered Employee and the covered spouse die simultaneously or upon the death of the last surviving parent, the covered children may convert if they are of contracting age.

4. If the covered spouse is no longer a qualified family Covered Person, the spouse may convert.

5. If a Covered Dependent child is no longer an Eligible Dependent as defined in this Group Plan, such dependent may convert.

At the time of application, You will be offered a choice of at least two plans; the Standard Conversion Plan and another plan in which benefits are substantially similar to the level of benefits in this Group Plan. The new coverage will be issued at rates, not to exceed 200% of the Standard Risk Rate as determined and published by the Office.

REQUESTING CONVERSION

A Covered Person who is eligible for conversion may obtain conversion coverage without having to submit evidence of health qualification. However, the Covered Person must apply in writing and pay the first

Premium for the conversion plan within 63 days after his or her coverage under this Group Plan terminates. The application form to be used and information about conversion benefits may be obtained from the Plan.

If the Employer qualifies for federal continuation benefits described in the Federal Continuation section, or qualifies for State Continuation as described above, conversion may take place at the end of the federal or state continuation period, if written application is made and the first Premium payment is made within 63 days of the date coverage under the continuation period ends.

Unless otherwise prohibited by law, conversion is not available if:

1. The Covered Person has not been continuously covered for at least three months under this Group Plan and/or under another group plan providing similar benefits, in effect, immediately prior to the termination of this Group Plan. However, dependents who are Covered Persons on the date coverage ends may convert as dependents of the Covered Employee if the Covered Employee converts coverage under this Group Plan; or

2. Coverage under this Group Plan ends due to failure to pay any required Premium; or

3. This Group Plan is replaced by similar group coverage within 31 days of the termination date of this Group Plan; or

4. The Covered Person has left the Plan's geographic area with the intent to relocate or establish a new residence

5. The Covered Person is eligible for the following coverage and those benefits together with the benefits provided by the conversion plan would result in excessive duplication of benefits:

    a. Any arrangements of coverage for individuals in a group whether on an insured or uninsured basis;

    b. Similar benefits under any state or federal program;

    c. Similar benefits by another group hospital, surgical, medical or major medical expense insurance Contract or group hospital and medical service plan or group medical practice or any other prepayment plan or program.

THIS HEALTH PLAN AND OTHER PAYMENT ARRANGEMENTS

COORDINATION OF BENEFITS

When a covered person is covered under this Health Plan and another health coverage plan, the Health Plan shall reserve the right to coordinate the benefits of this Health Plan with the benefits of the other health plan. This provision explains how coordination shall take place.

Coordination of benefits is designed to avoid the costly duplication of payment for health care services and/or supplies under multiple health coverage plans. The sum of the benefits that will be payable under all plans shall not exceed 100 percent of the total allowed expenses actually incurred.

Nothing in these provisions shall prevent the member from receiving the services of this plan under all of the terms and conditions which apply to those services. If a covered person receives services from Us, and as described in the Order of Benefit Determination section, those services would have been provided by another plan, We reserve the right to recover the reasonable value of such services as described in this section.

PLANS AFFECTED

If a covered person has any other health plan which covers at least a portion of a health care service or supply which is covered under this Health Plan, coordination shall take place. Not all health coverage plans shall be considered in this coordination process. The plans that shall be considered are the following:

1. Any group insurance, group self-insurance or health maintenance organization plan; including coverage under labor-management, trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;

2. Any service plan contracts, group practice, individual practice, or other prepayment coverage on a group basis;

3. Any plan, program or insurance established pursuant to workers' compensation legislation or other legislation of similar purpose;

4. Any non-group insurance policy, including an automobile insurance policy, provided that policy contains a coordination of benefits provision; or

5. Any coverage under governmental programs including Medicare, and any coverage required or provided by any statute.

Each policy, plan, or other arrangement with coverage for medical benefits or services that the covered person has shall be considered separately when determining the coordination of its benefits with this Health Plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed a paid benefit.

ORDER OF BENEFIT DETERMINATION

If the health benefits of all of the health coverage plans under which the covered person is covered exceed 100 percent of the total reasonable expenses actually incurred, the coordination process shall reduce the payment of one or more of the plans to eliminate any excess payment. The following guidelines shall be used to determine the order in which companies shall be considered and the appropriate benefit payment:

1. The first guideline is dependent status. The plan which covers the person receiving the service as an employee shall be the primary payor before the plan which covers the person as a dependent;

2. The second guideline is the "parent birth date rule" used in the case of a dependent child covered under both parent's plans and the parents are not divorced. The plan of the parent whose date of birth, excluding year, occurs earlier in the calendar year shall be the primary payor before the plan of the parent whose date of birth, excluding year, occurs later in a calendar year. If both parents have the same birth date, the plan with the earliest effective date shall be the primary payor. If one of the plans is administered in a state that does not use the parent birth date rule, the "gender rule" shall apply. The male parent's plan shall be primary.

3. In the case of a claim made for a dependent child whose parents are separated or divorced, the divorce decree shall establish the primary payor, or:

    a. If the divorce decree orders the parents to share equal responsibility, the plan of the parent with custody shall be the primary payor; or

    b. If the divorce decree orders the parents to have joint custody and responsibility, the plan with the earliest effective date for the child shall be the primary payor.

4. If there is no divorce decree, the plan of the parent with custody shall be primary. If the parent with custody remarries, the order of payment shall be: 1) plan of the parent with custody, 2) plan of step-parent, or spouse of the parent with custody, and 3) plan of parent without custody.

5. When rules 1, 2, 3 or 4 do not establish an order of benefit payment, the plan which has covered the person for the longer period shall be primary payor before the plan which has covered such person the shorter period of time, provided that:

    a. The plan covering the person as an active employee shall be payable before any other plan covering such person as a laid-off or retired employee or dependent of such person;

    b. The plan which had covered the retired covered person as an active employee shall be payable before any other plan covering such person as a dependent of another retired person; or

    c. If either plan does not have an order of determination provision regarding laid-off or retired employees then the provisions of 5.a. above shall not apply.

SUBROGATION

Situations that cause a covered person to need the benefits and supplies provided under this Health Plan may also result in actions by the covered person to recover damages related to that situation. Such actions may often result in duplicate payments for the services and supplies that the Health Plan has already provided to the covered person.

To protect the Health Plan from this type of duplicate payment, the Health Plan reserves the right to become involved in that recovery process. The Health Plan's right to become involved is called "subrogation."

1. If the Health Plan has paid for services or supplies under this Health Plan, the covered person shall, to the extent of such services or supplies, have subrogated the Health Plan to all causes of action and rights of recovery that the covered person may have or has against any persons and/or organizations that are related to the incident that necessitated the rendering of the services or supplies. These subrogation rights extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated.

2. The covered person shall promptly execute and deliver instruments and papers related to these subrogation rights as requested by the Health Plan. Further, the covered person shall promptly notify the Health Plan of any settlement negotiations prior to entering into a settlement agreement affecting the Health Plan's subrogation rights.

3. In no event shall a covered person fail to take any action where action is appropriate, or take any action that may prejudice the Health Plan's subrogation rights. No waiver, release of liability, settlement, or other documents executed by a covered person without prior notice to and approval by the Health Plan, shall be binding upon the Health Plan.

4. The Health Plan retains the right to recover such payments and/or the reasonable value of the benefits provided from any person or organization to the fullest extent permitted by law.

RIGHT TO RECEIVE AND RELEASE INFORMATION

The covered person shall give permission for the Health Plan or its representatives to obtain from or release to other insurance carriers or health care providers information necessary for processing claims and/or determining other carrier liability. Covered persons shall cooperate with the Health Plan or its representatives in its effort to obtain such information by, among other ways, signing any release of information form as requested by the Health Plan or its representatives.

FACILITY OF PAYMENT

Whenever payment, which should have been made by the Health Plan, is made by any other plan, the Health Plan shall pay to that other plan any amounts the Health Plan determines to be necessary under the coordination of benefits provision. Amounts paid to another plan in this manner shall be considered benefits paid under this Health Plan. The Health Plan is discharged from liability under this Health Plan to the extent of any amounts so paid.

RIGHT OF RECOVERY

If the Health Plan makes larger payments than are required under this Health Plan, the Health Plan shall have the right to recover any excess benefit payment from any person or organization to or for whom such payments were made, or any other person or organization the Health Plan may determine.

NON-DUPLICATION OF GOVERNMENT PROGRAMS

The benefits of this Health Plan shall not duplicate any benefits for which covered persons are paid, under governmental programs such as Medicare, Veterans Administration, CHAMPUS, or any Workers' Compensation Act, to the extent allowed by law. In any event, if this Health Plan has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to the Health Plan to the extent of such duplication.

NON-DUPLICATION OF OTHER COVERAGE

The benefits under this Health Plan shall not duplicate any benefits for which covered persons are paid under any extension of benefits and/or coverage provisions of any other plan, policy, program, or contract.

Where duplicate coverage exists, We reserve the right to be repaid by whomever has received the overpayment to the extent of the duplicate coverage.

COOPERATION OF COVERED PERSONS

Each covered person shall cooperate with the Health Plan, and shall execute and submit to the Health Plan such consents, releases, assignments, and other documents as may be requested by the Health Plan in order to administer and exercise its rights under the subrogation provision or to process claims. Failure to do so may result in the reduction of benefit payments under this Health Plan.

MEDICARE ELIGIBLES

The Effect of Medicare Coverage/Medicare Secondary Payer
When a Covered Person becomes covered under Medicare and continues to be eligible and covered under the Group Plan, the benefits of the Group Plan shall be primary and the Medicare benefits shall be secondary as set forth below, but only to the extent required by law. In all other instances, the benefits under this Group Plan shall be secondary to any Medicare benefits. To the extent the Plan is primary payer, claims for Covered Services should be filed with the Plan first.

In order to ensure compliance with the Medicare Statute, the Employer should advise the Plan of any Covered Person who is covered under Medicare prior to or immediately following the date such Covered Person becomes so covered (e.g., prior to the Covered Person's 65th birthday). Additionally, the Employer should advise the Health Plan of any Medicare beneficiary who applies for coverage, prior to such individual's Effective Date.

In any circumstances under which the Medicare statute requires that the Benefits under the Group Plan be primary for any Covered Person, the Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such Covered Person. Also, the Employer may not induce such Covered Person to decline or terminate his or her group health coverage and elect Medicare as primary payer.

Working Elderly

The Group Plan provides primary coverage for employees and/or their spouses, age 65 or older, who are covered under this Group Plan, pursuant to the following terms:

1. The Employer provides the Plan the names of employees, age 65 or older:

    a. Who are covered under this Group Plan.

    b. Who are employed (not retired).

    c. Who have not elected Medicare as primary payer of their health insurance claims.

    d. Who are not eligible for Medicare due to end stage renal disease (ESRD).

2. The Employer provides the Plan the names of spouses, age 65 or older, of current employees of any age:

    a. Who are covered under the Group Plan.

    b. Who have not elected Medicare as primary payer of their health insurance claims.

    c. Who are not eligible for Medicare due to ESRD.

These names, along with any other identifying information requested by the Plan should be provided to the Plan on or before the 65th birthday of the employee or spouse or on or before such later date when the individual enrolls under the Group Plan.

1. For an enrolled individual who meets one of the descriptions set out in Paragraph 1 or 2 above, the Plan will provide group health coverage, as set forth in the Group Plan, on a primary basis beginning with the first day of the month in which the individual attains age 65 or the date of enrollment, if the individual is 65 or over at the time of enrollment.

2. Individual entitlement to primary coverage under this Section will terminate automatically:

    a. For a current employee, age 65 or older, when he or she elects Medicare as the primary payer or when he or she becomes eligible for Medicare due to ESRD;

    b. For the spouse, age 65 or older, of a current employee of any age, when the spouse elects Medicare as the primary payer or when the spouse becomes eligible for Medicare due to ESRD.

The Employer notifies the Plan the names of any current employees or spouses of such employees, age 65 or older, who choose Medicare as primary payer of their health insurance claims or who become eligible for Medicare due to ESRD.

Under the Medicare statute, the Employer may not offer, subsidize, procure, or provide a Medicare supplement insurance policy to such individual. Also, the Employer may not induce such individual to decline or terminate his or her group health coverage and elect Medicare as primary payer.

Entitlement of the employee and/or spouse to primary coverage under this Section will terminate automatically when:

    a. The employee retires; or

    b. The employee no longer meets the employer eligibility requirements.

Individuals with End Stage Renal Disease

Primary coverage is provided for the Employer's current and former employees and/or their dependents who are covered under the Group Plan and who are entitled to Medicare coverage because of ESRD, pursuant to the following terms:

1. The Employer provides the Plan with the names of any individuals covered under the Group Plan who are or will be undergoing a regular course of renal dialysis or who will receive or already have received a kidney transplant, the beginning date of such dialysis or the date of such transplant, and any other identifying information requested.

2. For an enrolled individual who is entitled to Medicare coverage because of ESRD, the Plan will provide group health insurance coverage, as set forth in this Group Plan, on a primary basis for 30 months beginning with the earlier of:

   a. The month in which the individual becomes entitled to Medicare Part A ESRD benefits; or

   b. The first month in which the individual would have become entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the gage of 65). Also, if group health coverage was primary prior to ESRD entitlement, then the Group will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD on or after March 1, 1996, the Plan will provide group health coverage, as set forth in the Group Plan, on a primary basis for 18 months.

Under the Medicare statute, the Employer may not offer, subsidize, procure, or provide a Medicare supplement policy to such individuals. Also, the Employer may not induce such individuals to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

Conformance with Federal Law

This Medicare Secondary Payer Section shall be subject to, modified if necessary to conform to or comply with, and interpreted with reference to those requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Group Plan.

NOTE: The federal laws described in this Section are directed at the Employer. Individuals with questions regarding their rights under those laws should direct their questions to the Employer.

REIMBURSEMENT FOR NON-PARTICIPATING PROVIDER SERVICES

The Health Plan shall provide or arrange for covered services to be received from participating providers on a direct service basis. If a covered person receives covered services from a participating provider, the Health Plan shall pay the provider directly for all care received. The covered person shall not have to submit a claim for payment, and shall be responsible only for any applicable copayments.

In the event that a Covered Person receives emergency services from a non-participating provider either inside or outside of the Plan's Service Area; or if We refer you to a non-participating provider, We will arrange for direct payment to the non-participating provider at the Usual and Customary Rate. Usual and Customary means those costs for services or supplies which are no higher than the 80th percentile of prevailing health care charge data. This data, developed by independent organizations and fee schedule companies shall reflect a current statistical sampling of the charges for services and supplies made in that same area or in a comparable area. The Covered Person shall not be responsible for any balance billing that results from the receipt of emergency services from any participating or non-participating provider.

The following provisions apply in the event the covered person needs to file a claim for non-participating provider services:

CLAIM FORMS

Claim forms may be required for submission of a proof of loss by a covered person for non-participating provider services.

As this procedure varies for health maintenance organizations, the covered person is responsible for following the procedures established by the Health Plan.

PROOF OF LOSS

For services rendered by non-participating providers, written proof of loss shall be given to the Health Plan. If proof of loss is not submitted and received by the Health Plan within the Health Plan's required time period, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit written proof of loss within the allowed time period and that the proof was submitted as soon as possible, the claim shall not be reduced or invalidated. Benefits will be paid upon receipt of proper written proof of loss.

ASSIGNMENT OF CLAIM

For covered services rendered by non-participating providers, benefits shall be payable to the covered person less any applicable co-payments which are the responsibility of the covered person. The Health Plan may pay all or any part of the benefits to the health care provider on whose charge the claim is based. The Health Plan is under no obligation to honor such assignments from non-participating providers.

UNUSUAL CIRCUMSTANCES

If the rendering of services or benefits under this plan is delayed or impractical due to: (a) complete or partial destruction of facilities; (b) war; (c) riot; (d) civil insurrection; (e) major disaster; (f) disability of a significant part of a participating hospital and practitioner network; (g) epidemic; (h) labor dispute not involving the Health Plan, participating providers shall use their best efforts to provide services and benefits within the limitations of available facilities and personnel. However, neither the Health Plan, nor any participating providers shall have any liability or obligation because of a delay or failure to provide such services or benefits. If the rendering of services or benefits under this Health Plan is delayed due to a labor dispute involving the Health Plan or participating providers, non-emergency care shall be deferred until after the resolution of the labor dispute.

GRIEVANCE PROCEDURE

Introduction

The JMH Health Plan [(hereinafter referred to as the Plan)] has a grievance and appeal procedure, which complies with applicable state and federal law ("The Grievance Procedure"). We will try to resolve any problems you may encounter over the telephone, but sometimes, additional steps are necessary. In these cases, we have a Grievance Procedure available that provides channels for you, or a provider acting on your behalf, to voice your concerns and have them reviewed and addressed at several levels within the organization.

Definitions

The following terms, as used in this section, are defined as follows:

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under this Policy with respect to a Pre-Service Claim or a Post-Service

Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in this Section, shall also constitute an Adverse Benefit Determination.

Claim Involving Urgent Care means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to the Member with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize the Member's life or health or his or her ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the Member's Condition, would subject the Member to severe pain that cannot be adequately managed without the proposed services being rendered.

Concurrent Care Decision means a decision by the Plan to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if the Plan had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to the Member (not just proposed or recommended) that is received by the Plan in a format acceptable to the Plan in accordance with the provisions of this Section.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to the Member and with respect to which the terms of this Policy conditions payment for Services (in whole or in part) on approval by the Plan of coverage or benefits for the Services before the Member receives the Service. A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by the Plan regarding coverage, benefits, or payment for a Service that has not actually been rendered to the Member if the terms of this Policy do not require approval by the Plan of coverage or benefits (or condition payment) for the Service before it is received.

Claim and Appeal Procedures

There are three types of claims: (1) Pre-Service Claims; (2) Post-Service Claims; and (3) Claims Involving Urgent Care. It is important that Members become familiar with the types of claims that can be submitted to the Plan and the time frames and other requirements that apply.

A. Urgent Care Claims

Initial Claim - An Urgent Care Claim shall be deemed to be filed on the date received by the Plan. We shall notify the Member of Our benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after We receive, either orally or in writing, the Urgent Care Claim, unless the Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Health Plan. If such information is not provided, the Plan shall notify the Member as soon as possible, but not later than 24 hours after We receive the Claim, of the specific information necessary to complete the Claim. The Member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the Member of Our benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

1. The Plan's receipt of the specified information; or
2. The end of the period afforded the Member to provide the specified additional information.

If the Member fails to supply the requested information within the 48-hour period, the Claim shall be denied. The Plan may notify the Member of its benefit determination orally or in writing. If the notification is provided orally, a written or electronic notification shall be provided to the Member no later than 3 days after the oral notification. A Member or a provider acting on behalf of the Member, who is not satisfied with the benefit determination, may appeal an Urgent Care Claim to:

Subscriber Assistance Panel (SAP)

Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 26
Tallahassee, Florida 32308
Telephone 1-888-419-3456 or 850-921-5458

B. Pre-Service Claims

Initial Claim – A Pre-Service Claim shall be deemed to be filed on the date received by the Plan. We shall notify the Member of Our benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after We receive the Pre-Service Claim. The Plan may extend this period one time for up to 15 days, provided that the Plan determines that such an extension is necessary due to matters beyond control and notifies the Member, before the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Health Plan expects to render a decision. If such an extension is necessary because the Member failed to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the notice within which to provide the specified information

In the case of a failure by a Member to follow the Plan's procedures for filing a Pre-Service Claim, the Member shall be notified of the failure and the proper procedures to be followed in filing a Claim for benefits not later than five (5) days following such failure. The Plan's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information. If the Member fails to supply the requested information within the 45-day period, the Claim shall be denied. A Member may appeal a Pre-Service Claim as set forth in the Appeals Section.

C. Post-Service Claims

Initial Claim – A Post-Service Claim shall be deemed to be filed on the date received by Health Plan. The Plan shall notify the Member of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after the Health Plan receives the Post-Service Claim. The Health Plan may extend this period one time for up to 15 days, provided that the Plan determines that such an extension is necessary due to matters beyond the Plan's control and notifies the Member, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Health Plan expects to render a decision. If such an extension is necessary because the Member failed to submit the information necessary to decide the Post-Service Claim, the notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. The Plan's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information. If the Member fails to supply the requested information within the 45-day period, the Claim shall be denied. A Member may appeal a Post-Service Claim as set forth in the Appeals Section.

D. Appeals

A Member may appeal a Pre-Service Claim, or Post-Service Claim within 180 days of receiving the benefit determination. The Plan shall notify the Member, of Our benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the JMH Health Plan receives the Member's request.

You may submit an appeal to:

Attention: Grievance Coordinator
JMH Health Plan

155 South Miami Ave, Suite 110
Miami, FL 33130
Phone: 305-575-3640 or 1-800-721-2993
Fax: (305) 545-5212

If you are not satisfied with the Plan's final decision, you may contact the Florida Agency for Health Care Administration (AHCA) or the Florida Department of Financial Services (FDFS), Division of Consumer Services in writing within 365 days of receipt of the final decision letter. You also have the right to contact AHCA or FDFS at any time to inform them of an unresolved grievance.

The Agency for Health Care Administration's Subscriber Assistance Program will not hear a grievance if the Member has not completed the entire the Plan Grievance process nor if the member has instituted an action pending in the state or federal court.

Subscriber Assistance Panel (SAP)
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 26
Tallahassee, Florida 32308
Telephone 1-888-419-3456 or 850-921-5458

The Florida Department of Financial Services
Division of Consumer Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone 1-877-693-5236

General Information and Procedures

A. Concurrent Care Claims

Any reduction or termination by the Health Plan of Concurrent Care (other than by plan amendment or termination) before the end of an approved period of time or number of treatments shall constitute an Adverse Benefit Determination. The Plan shall notify the Member of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of the Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that relates to an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the Member of the benefit determination, whether adverse or not, within 24 hours after the Health Plan receives the Claim, provided that any such Claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments. Notification and appeal of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, shall be made in accordance with this Grievance Procedure.

B. Initial Claim Determination Notice

The Plan shall provide a Member with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Member, the following:

1. The specific reason(s) for the Adverse Benefit Determination**.**
2. Reference to the specific Health Plan provisions on which the determination is based.
3. A description of any additional material or information necessary for the Member to perfect the claim and an explanation of why such material or information is necessary.

4. A description of the Plan's review procedures and the time limits applicable to such procedures, including, when applicable a statement of the Member's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), following an Adverse Benefit Determination on final review.
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Member upon request.
6. If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the Member's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.
7. In the case of an Adverse Benefit Determination involving an Urgent Care Claim, a description of the expedited review process applicable to such Claim.

C. Review Procedures upon Appeal

The Plan's appeal procedures shall include the following substantive procedures and safeguards:

1. Member may submit written comments, documents, records, and other information relating to the claim.
2. Upon request and free of charge, the Member shall have reasonable access to and copies of any Relevant Document.
3. The appeal shall take into account all comments, documents, records, and other information the Member submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
4. The appeal shall be conducted by an appropriate named fiduciary of the Health Plan who is neither the individual who made the initial Adverse Benefit Determination nor the subordinate of such individual. Such person shall not defer to the initial Adverse Benefit Determination.
5. In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational or not Medically Necessary, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
6. The appeal shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Health Plan in connection with a Member's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.
7. The appeal shall provide that the Health Care Professional engaged for purposes of a consultation for an Adverse Benefit Determination, shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
8. In the case of an Urgent Care Claim, there shall be an expedited review process pursuant to which:

    a. a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Member; and
    b. all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Health Plan and the Member by telephone, facsimile, or other available similarly expeditious methods.

D. Appeal Notification

The Plan shall provide a Member with written or electronic notification of the Plan's benefit determination upon review.

In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Member, all of the following, as appropriate:

1. The specific reason(s) for the Adverse Benefit Determination.
2. Reference to the specific Health Plan provisions on which the Adverse Benefit Determination is based.
3. A statement that the Member is entitled to receive, upon request, and free of charge, reasonable access to, and copies of any Relevant Document.
4. A statement describing any voluntary appeal procedures offered by the Health Plan and the Member's right to obtain the information about such procedures and a statement of the Member's right to bring an action under ERISA Section 502(a) when applicable.
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Member upon request.
6. If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the Member's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.

COVERAGE PROVISIONS

This section provides important information on the coverage provided under the Health Plan explaining:

1. What rules the covered person shall follow in accessing care;

2. What services and supplies are covered; and

3. What services and supplies are not covered.

COVERAGE ACCESS RULES

It is important that Health Plan covered persons become familiar with the rules for accessing health care services through the Health Plan. The following sections explain the role of the Health Plan and the primary care physician, how to access specialty care through the Health Plan and the primary care physician, and what to do if emergency care is needed.

THE ROLE OF THE PRIMARY CARE PHYSICIAN

The first and most important decision each covered person must make when joining a health maintenance organization is the selection of a primary care physician. The covered person is free to choose any primary care physician listed in the Health Plan's list of primary care physicians whose practice is open to additional Health Plan covered persons. This choice should be made when the covered person enrolls. It is recommended that you verify the physician's status by calling the Health Plan's Member Services Department or visiting the Health Plan's website. Members who are enrolled in an Open Access Plan are not required to select a primary care physician. If the covered person is enrolled in a Plan that requires the selection of a primary care physician and fails to make a selection, the Health Plan shall assign one to the covered person and notify the covered person of that assignment.

The JMH Health Plan has arranged for a nationwide network which is referred to as the Premier Access Network. In most cases this will allow retirees and dependents who attend college living outside the service area to receive in-network benefits, regardless of which HMO plan you are enrolled in. It will also allow members to access in-network benefits while traveling if medical care is necessary.

Some important guidelines apply to the covered person's primary care physician relationship:

1. The primary care physician shall maintain a physician-patient relationship with the Member, and shall be responsible for providing, or coordinating all medical services for the Member. If you have an "Open Access Plan", a referral is not necessary for most in-network specialty physician services. The "Specialty Care" provision details those services requiring a PCP referral. Your Member ID card will indicate if you have an Open Access Plan.

2. The Member must look to the primary care physician to direct his or her care, and should accept procedures and treatment recommended by the primary care physician.

3. Except for emergency medical conditions or as otherwise directed by the Health Plan, all services shall be received from the covered person's primary care physician or from participating providers including provides from within the Premier Access Network. If the Covered Person uses a health care provider that is not a participating provider, services shall not be reimbursed by the Health Plan. In addition, if a Covered Person receives services requiring authorization without receiving such authorization from the Health Plan, services shall not be reimbursed by the Health Plan.

4. The Health Plan wants the covered person and the primary care physician to have a good relationship. Instances may occur where the primary care physician or the covered person, for good cause, finds it

impossible to establish an appropriate and viable physician-patient relationship. In such a circumstance, the primary care physician or the covered person may request another primary care physician.

5. If for any reason the primary care physician or other contracting health care provider fails to or is unable to provide the covered person with services they have agreed to provide, the Health Plan agrees to provide, arrange or pay for services equivalent to those described in the covered services section up to the date for which payment has been made by the covered person.

6. When a contract between the Plan and a treating provider is terminated for any reason other than for cause, each party shall allow Covered Person for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the Covered Person was receiving care at the time of the termination, until the Covered Person selects another treating provider, or during the next open enrollment period, whichever is longer, but not longer than 6 months after termination of the contract. Each party to the terminated contract shall allow a Covered Person who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to a Covered Person who is abusive, non-compliant, or in arrears in payments for services provided. For care continued under this provision, the Plan and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

SPECIALTY CARE

The Member shall have direct access to specialty care physicians without a referral from the primary care physician except for general surgery and plastic surgery consultations. This applies only to a Member with an Open Access Plan. Direct access to gynecologists, dermatologists, chiropractors, podiatrists and other practitioners as specified by law applies to all Members regardless of Plan type. Members have the right to select a specialist, as long as the specialist is a participating provider and qualified to provide the necessary treatment. Elective admissions; outpatient procedures; Durable Medical Equipment; physical, occupational, and speech therapy; Home Health services and plastic surgery, and certain diagnostic procedures require a referral from the primary or specialty care physician and authorization from the Health Plan.

If a specialist beyond those participating with the Health Plan is required, the primary care physician shall refer for such treatment with proper authorization from the Health Plan. As the procedures for specialty care vary for health maintenance organizations, the Member is responsible for following the procedures established by the Health Plan.

EMERGENCY SERVICES AND CARE

The procedure the Covered Person should follow for Emergency Services and Care for an Emergency Medical Condition as defined in this Group Plan, depends on whether the treatment is rendered inside or outside the Service Area. In either instance, if the use of a Participating or Non-Participating Hospital Emergency Room is not due to an Emergency Medical Condition or a Condition covered by this Group Plan, the only payment made will be for the determination of whether an Emergency Medical Condition existed. If an Emergency Medical Condition did not exist, no further benefits will be paid.

Within The Service Area

If Emergency Services and Care are required within the Service Area, the Covered Person must notify the Plan and his/her Primary Care Physician. The Covered Person should, in the instance of an Emergency Medical Condition, seek Emergency Services and Care and then contact the Plan and his/her Primary Care Physician, not later than 48 hours after services are received, if the Covered Person is lucid and able to communicate. If not, the Covered Person or a member of the Covered Person's family should notify the Plan and his/her Primary Care Physician as soon as reasonably possible.

Outside The Service Area

Emergency Services and Care for an Emergency Medical Condition provided outside the Service Area will be covered if the Covered Person sustains an accidental injury or becomes ill while temporarily away from the Service Area.

If the Covered Person requires treatment for an Emergency Medical Condition while outside the Service Area, Emergency Services and Care may be sought. Only initial treatment is covered without the Plan's approval. The Covered Person should notify the Plan and Primary Care Physician as soon thereafter as is practical, so that the Primary Care Physician and the Plan may initiate necessary follow-up care.

If the Covered Person is admitted to a Hospital for an Emergency Medical Condition, by a Physician other than the Covered Person's Primary Care Physician, the Covered Person or a member of the Covered Person's family should notify the Plan and the Primary Care Physician at the earliest time reasonably possible to allow the Primary Care Physician to coordinate any necessary follow-up care.

COVERED PERSON COPAYMENTS

For certain services, the covered person is responsible for paying a portion of the cost of covered services. Usually, this portion is a flat dollar amount referred to as a copayment. The copayment requirements for this Health Plan are shown in the schedule of member copayments.

The total copayments the covered person is responsible for in any single calendar year shall not exceed the amount as specified your Schedule of Benefits for individual and family coverage. When the covered person has paid copayments that total the annual maximum, no further copayments shall be required by that covered person for the remainder of the calendar year. The covered person may also call the Health Plan's customer service department for information on copayment amounts and the status of the annual out of pocket maximum.

DEDUCTIBLE

Before the JMH Health Plan will begin paying expenses for services covered under this Health Plan, you must satisfy the annual Deductible specified in the Benefit Schedule. The Deductible means the amount a Member must pay each calendar year for covered services from his or her own pocket before the JMH Health Plan will make payments for eligible expenses. The individual Deductible or family Deductible as specified in the Schedule of Benefits must be satisfied each calendar year before any payment will be made by the JMH Health Plan for any claim.

If you have family coverage, once the sum of the Individual Deductible satisfied for the calendar year reaches the Family Deductible requirements, no further Deductible will be required from any family member for the remainder of the calendar year. The maximum amount for any family member that JMH will apply towards satisfying the Family Deductible is his/her Individual Deductible.

Any eligible expenses credited by the JMH Health Plan towards your Deductible requirement during the last three months of this Group Plan's prior calendar year, will be reduced to the extent of such application for the next ensuing calendar year.

Only those eligible expenses submitted on claims to the JMH Health Plan will be credited toward the Deductible. Expenses that are not eligible will not be counted toward the satisfaction of the Deductible

LIFETIME MAXIMUM COVERAGE LIMIT

There is no lifetime maximum coverage limit under this Health Plan.

COVERED BENEFITS SECTION

This section describes the benefits that shall be covered under this Health Plan. It is important that this whole section be reviewed to be sure both covered benefit details and the limitations and exclusions are understood. Also, important information is contained in the schedule of member copayments.

Expenses for the services and supplies listed below shall be considered covered services under this Health Plan if the service is:

1. Required for a condition;

2. Rendered while coverage under this Health Plan is in force or in a case where the Extension of Benefit provision applies;

3. Not specifically limited or excluded under this Health Plan; and

4. Received from or provided under the orders, direction or authorized approval of the covered person's primary care physician or Health Plan, except for emergency care services, and consultations of in-network specialists, except general and plastic surgery consultations.

HOSPITAL SERVICES

Expenses for the services and supplies listed below shall be considered covered benefits when furnished to a covered person at a hospital on an inpatient or outpatient basis, if the service or supply is ordered or approved by the covered person's primary care physician and authorized by the Health Plan:

1. Room and board for semi-private accommodations, unless the Health Plan has determined that private accommodations are medically necessary;

2. Confinement in an intensive care unit, progressive care unit, cardiac care unit or a neonatal care unit;

3. Routine nursery care for a newborn child;

4. Covered drugs and medicines used by the patient while confined in the hospital;

5. Respiratory therapy (including oxygen);

6. Covered rehabilitative services;

7. Use of operating rooms, labor rooms, delivery rooms, and recovery rooms;

8. Use of emergency rooms;

9. Intravenous solutions (including glucose);

10. Dressings, including ordinary casts, splints and trusses;

11. Anesthetics, related supplies, and their administration;

12. Transfusion supplies, services, and equipment (including blood, blood plasma, and serum albumin, if not replaced);

13. Diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (including electrocardiogram (EKG) and electroencephalogram (EEG));

14. X-ray (including therapy);

15. Diathermy;

16. Basal metabolism examinations;

17. Chemotherapy treatment for proven malignant disease;

18. Medically necessary and approved private duty nursing; and

AMBULATORY SURGICAL CENTER SERVICES AND OTHER LICENSED OUTPATIENT MEDICAL TREATMENT FACILITIES

Expenses for the services and supplies listed below shall be considered covered benefits when furnished to a covered person at a participating provider ambulatory surgical center, any other appropriately licensed outpatient medical treatment facility, or a health care provider's office, if approved by the covered person's primary care physician and authorized by the Health Plan:

1. Use of operating rooms and recovery rooms;

2. Respiratory therapy (including oxygen);

3. Covered drugs and medicines used by the patient at the outpatient facility;

4. Intravenous solutions (including glucose);

5. Dressings, including ordinary casts, splints, and trusses;

6. Anesthetics, related supplies, and their administration;

7. Transfusion supplies, services, and equipment (including blood, blood plasma, and serum albumin, if not replaced);

8. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (including electrocardiogram, (EKG) and electroencephalogram (EEG));

9. Basal metabolism examinations;

10. X-ray (including therapy);

11. Diathermy and physical therapy,

12. Chemotherapy treatment for proven malignant disease;

13. Services provided by a birthing center licensed pursuant to section 383.30-383.335, Florida Statutes.

MEDICAL SERVICES

Expenses for the medical services and supplies listed below shall be considered covered benefits if provided or approved by the covered person's primary care physician and authorized by the Health Plan:

Alcoholism and substance abuse treatment, including expenses for the services and supplies listed in this section shall be considered covered benefits if provided to the covered person by a participating provider:

1. Inpatient confinement in a hospital, specialty institution, or residential facility for the treatment of alcoholism or substance abuse, if authorized by the Health Plan. Treatment shall be rendered by licensed mental health providers if services are provided in a facility accredited by the Joint Commission on Accreditation of Hospitals or approved by the state Coverage is limited as set forth in the Schedule of Benefits.

2. Outpatient treatment rendered by licensed mental health providers and medical doctors licensed under chapter 458, and doctors of osteopathy licensed under chapter 459, Florida Statutes, if services are provided in a program accredited by the Joint Commission on Accreditation of Hospitals or approved by the state. Coverage is limited as set forth in the Schedule of Benefits.

Allergy treatment, including allergy testing, desensitization therapy, and allergy immunotherapy, including hyposensitization serum when administered by a health care provider.

Ambulance services, when medically necessary to transport to the nearest medical facility capable of providing required Emergency Services and care to determine if an Emergency Medical Condition exists. .
Anesthesia services, when administered by a health care provider and medically necessary for a covered medical or surgical procedure.

Anesthesia and Hospital Services, for dental treatment or surgery when the dental condition is likely to result in a medical condition if left untreated and for the safe delivery of necessary dental care provided to a member who is under 8 years of age and is determined by a licensed dentist, and the member's physician to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or the member has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

Breast cancer treatment: Coverage for breast cancer treatment includes inpatient hospital care and outpatient post-surgical follow-up care for mastectomies when medically necessary in accordance with prevailing medical standards. Coverage for outpatient post-surgical care is provided in the most medically appropriate setting which may include the hospital, treating physician's office, outpatient center, or the Covered Person's home. Inpatient hospital treatment for mastectomies will not be limited to any period that is less than that determined by the Attending Physician.

Coverage for mastectomies includes:
1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining a pre-existing condition unless evidence of breast cancer is found during or as a result of the follow-up care.

Cancer diagnosis and treatment, on an inpatient or outpatient basis, including chemotherapy treatment, covered transplants, x-ray, cobalt, and other acceptable forms of radiation therapy, microscopic tests or any covered lab tests or analysis made for diagnosis or treatment.

Cardiac Rehabilitation includes medically necessary rehabilitative services for conditions including, acute myocardial infarction, Percutaneous Transluminal Coronary Angioplasty (PTCA), repair or replacement of heart valves, Coronary Artery Bypass Graft (CABG), or heart transplant. Refer to your Benefit Summary for copayments and limitations.

Child health supervision services means physician-delivered or physician-supervised services that include periodic visits which shall include a history, a physical examination, a developmental assessment, and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Chiropractic services, provided by a participating Plan Provider without the need for referral from the Primary Care Physician as set forth in the schedule of benefits. Any procedures or treatments must be authorized by the Plan.

Cleft lip and cleft palate treatment is provided for a dependent under age eighteen (18). Coverage includes medical, dental, speech therapy, audiology, and nutrition services if such services are prescribed by the Primary Care Physician or treating physician. Coverage is subject to benefit and benefit limitations listed in the Covered Benefits and General Exclusions sections of this Group Plan.

Concurrent physician care, including surgical assistance provided by a physician, provided the additional physician actively participates in the covered person's treatment and: a) the condition involves more than one body system or is so severe or complex that one physician cannot provide the care unassisted; b) the physicians have different specialties or have the same specialty with different sub-specialties; and c) the care is authorized by the Health Plan.

Congenital or developmental abnormality treatment, including cleft lip and palate, provided the treatment, or plastic and reconstructive surgery is for the restoration of bodily function, or the correction of a deformity resulting from disease, injury or congenital or developmental abnormalities.

Consultations, provided the In-Network consulting physician prepares a written report.

Contraceptive supplies, including an IUD or diaphragm, their insertion and removal, contraceptive implants, their insertion and removal, and contraceptive injections.

Dermatology services: A Covered Person does not need to obtain a referral or prior authorization for dermatologic office visits

Diabetes treatment which includes all medically appropriate and necessary equipment, supplies, and services used to treat diabetes, including outpatient self-management training and educational services, if the patient's primary care physician, or the physician who specializes in treating diabetes, certifies that the equipment, supplies, or services are necessary.

Diagnostic procedures, lab tests or x-ray exams, including their interpretation, for the treatment of a covered condition.

Diagnostic or surgical procedures involving bones or joints of the skeleton shall be covered including any similar diagnostic or surgical procedure involving bones or joints of the jaw and facial region, if, under accepted medical standards, such procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

Durable medical equipment and other medical supplies, The Plan provides benefits, when Medically Necessary for purchase or rental of such Durable Medical Equipment that:

a) can withstand repeated use (i.e. could normally be rented and used by successive patients);

b) Is primarily and customarily used to serve a medical purpose;

c) Generally is not useful to a person in a person in the absence of illness or injury; and

d) Is appropriate for use in a patient's home.

The benefit for Durable Medical Equipment (DME) includes but is not limited to hospital beds, walkers, crutches, wheelchairs, apnea monitors, oxygen and its administration, fetal heart rate monitors, external cardiac defibrillators, vacuum assisted closure devices, and insulin pumps. Upon meeting medical criteria, insulin pumps and oxygen and its administration will not count toward the DME annual maximum but will continue to be covered by the Plan. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by JMH Health Plan. See your Benefit Summary for Co-payments and Limitations and the Exclusions Section.

Eye care, limited to the following:

1. One routine or refractive eye examinations annually as part of the preventive medical care benefit or child health supervision services benefit;

2. The first pair of eyeglasses or contact lenses, including the examination for the prescribing or fitting thereof, only if due to an accident or cataract surgery;

3. Aphakic patients and soft lenses or sclera shells intended for use in the treatment of a covered condition; and

4. Following an injury, disease or accident to a covered person's eyes, while covered under this Health Plan.

Family planning services, including counseling and information on birth control, sex education and the prevention of sexually transmitted diseases (STD).

Genetic testing that uses a proven testing method for the identification of genetically linked inheritable disease. Genetic testing is covered only if:

1. A person has symptoms or signs of a genetically-linked inheritable disease;

2. It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidenced based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact the clinical outcome; or

3. The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidenced-based, scientific literature to directly impact treatment options.

Genetic Counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre and post genetic testing.

Hemodialysis/peritoneal dialysis for renal disease, including the equipment, training and medical supplies required for effective home dialysis and dialysis centers.

Home health care services provided by a In-Network home health agency for the appropriate treatment, therapy (including infusion therapy), equipment, medication, and supplies for a covered person as a result of a covered condition shall be covered by the Health Plan, subject to the following:

1. The covered person requires home health care visits;

2. The treating physician sends the Health Plan and the Home Health Agency a home health care plan of treatment;

3. The covered person's treating physician approves and the Health Plan authorizes the plan of treatment in writing as being medically necessary and that the services are being provided in lieu of hospitalization or continued hospitalization; and

4. Home health care benefits would be less costly than confinement to a hospital or skilled nursing facility.

The covered person's treating physician or Health Plan shall review the covered person's condition to determine the medical necessity for home health care services. If the covered person's condition does not warrant the services provided by a home health agency, nurse registry or independent nurse, benefits shall be denied. At such time as documentation is provided for and benefits are found to be medically necessary and in lieu of hospitalization or continued hospitalization, benefits shall be reinstated.

Home health care services include:

1. Part-time, intermittent or continuous nursing care by registered nurses, or licensed practical nurses, nurse registries or home health agencies;

2. Physical therapy, speech therapy, occupational therapy and respiratory therapy; and

3. Medical appliances, equipment, laboratory services, supplies, drugs, and medicines prescribed by a covered person's treating physician and other covered services provided by or for a home health agency, through a licensed nurse registry, or by an independent nurse licensed under chapter 464, Florida Statutes, to the extent that they would have been covered if the covered person had been confined in a hospital.

The covered home health care services under this benefit shall not include any service that would not have been covered had the covered person been confined in a hospital, or are solely for the convenience of the covered person. Physical, speech and occupational therapy is subject to the limitations described under rehabilitative services.

Hospice services, in accordance with section 400.609, Florida Statutes, when hospice services are the most appropriate and cost effective treatment, as determined by the covered person's treating physician or Health Plan. Covered persons who are diagnosed as having a terminal illness with a life expectancy up to one year may elect hospice care for such illness instead of the traditional services covered under this Health Plan.

To qualify for coverage, the covered person's treating physician shall: (1) certify that the patient is not expected to live more than one year; (2) submit a written hospice care plan or program; and (3) submit a life expectancy certification. All hospice care expenses shall be approved in writing by the Health Plan. Covered persons who elect hospice care under this provision shall not be entitled to any other benefits under this Health Plan for the terminal illness while the hospice election is in effect. However, covered services rendered outside the hospice program for illnesses or accidents not related to the terminal illness shall be eligible for coverage subject to the Health Plan's benefits, limitations and exclusions. Under these circumstances, the following services shall be covered:

1. Hospice home care comprised of:

    a. Physician services, part-time or intermittent nursing care by a registered nurse or licensed practical nurse, or private duty nursing service;

    b. Home health aides;

    c. Inhalation (respiratory) therapy;

d. Oxygen;

e. Medical supplies, drugs and appliances;

f. Physical, massage, speech, and occupational therapy to maintain the quality of life, if approved by the Health Plan as appropriate for special circumstances; and

g. Infusion therapy.

2. Hospice inpatient care in a hospice facility, hospital, or skilled nursing facility if approved in writing by the Health Plan, including care for pain control or acute chronic symptom management. Inpatient services shall include:

a. Room and board and general nursing;

b. Other covered hospital inpatient services previously listed; and

c. All other services covered under home and outpatient hospice care.

3. Hospice outpatient care provided by the hospice at an approved location shall include:

a. Physician services;

b. Laboratory, x-ray, and diagnostic testing;

c. Ambulance service; and

d. All other services covered under home hospice care services.

Social work services, bereavement, pastoral, financial, legal and dietary counseling, day care, homemaker, chore and funeral services are required to be provided by the hospice provider pursuant to section 400.609, Florida Statutes. However, these services are not covered services under this Health Plan.

The hospice treatment program shall:

1. Meet the standards outlined by the National Hospice Association;

2. Be recognized as an approved hospice program by the Health Plan;

3. Be licensed, certified, and registered as required by Florida law; and

4. Be directed by the covered person's treating physician and coordinated by a registered nurse, with a treatment plan that provides an organized system of hospice facility care, uses a hospice team, and has around-the-clock care available.

Immunizations, when medically necessary.

Infertility Treatment limited to diagnostic testing and procedures performed specifically to determine the cause of infertility.

Insulin, including the needles and syringes needed for insulin administration when dispensed by a participating pharmacy or provider. However, the covered person shall have a physician's authorization for such supplies on record with the pharmacy where the supplies are purchased.

Mammograms performed for breast cancer screening, but limited to the following:

1. A baseline mammogram for women age 35 through 39;

2. A mammogram for women age 40 through 49, every two years or more frequently based upon the covered person's primary care physician's recommendation;

3. A mammogram every year for women age 50 and over; and

4. One or more mammograms a year, based upon a physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a biopsy-proven benign breast disease, because of having a mother, sister, or a daughter who has or has had breast cancer, or because a woman has not given birth before the age of 30.

Maternity care received on an inpatient or outpatient basis including Medically Necessary prenatal and postnatal care of the mother. These services include the services provided by certified nurse-midwives and midwives licensed pursuant to Florida Statutes, Chapter 467. The post delivery care shall include a postpartum assessment and newborn assessment and may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards. Services must be authorized by the Plan and shall be administered in accordance with the Newborn's and Mother's Protection Act (NMHPA). Please refer to the Schedule of Benefits to determine Co-Payment amounts.

Mental and nervous disorders treatment, including expenses for the services and supplies listed in this section shall be considered covered benefits if provided to the covered person by a licensed mental health provider:

1. Inpatient confinement in a hospital, specialty institution, or residential facility, for the treatment of a mental and nervous disorder, if authorized by the Health Plan. Coverage includes visits from licensed mental health providers during confinement. Coverage is limited as set forth in the Schedule of Benefits.

2. Outpatient treatment rendered by a licensed mental health provider and medical doctors licensed under chapter 458, and doctors of osteopathy licensed under chapter 459, Florida Statutes, for a mental and nervous disorder, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy. Coverage is limited as set forth in the Schedule of Benefits

Mental and nervous disorders treatment shall not be a covered benefit if: (a) rendered in connection with a condition not classified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, (b) extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation, (c) for marriage counseling, (d) court ordered care or testing or required as a condition of parole or probation, (e) testing for aptitude, ability, intelligence or interest.

Newborn coverage, benefits, or services shall be provided in accordance with the NMHPA and with respect to a newborn child of the subscriber, or covered Member of the Subscriber, from the moment of birth. Benefits for covered newborns shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn child.

Newborn hearing screening at birth and any Medically Necessary follow-up reevaluations leading to diagnosis are covered through age 12 months. Treatment and services covered under this Group Plan and delivered or approved by the child's Primary Care Physician will be provided to any Covered Dependent child diagnosed as having a permanent hearing impairment, when authorized by the Health Plan.

Nutrition counseling for any condition when medically necessary.

Obstetrician/Gynecologist (**one annual visit) services** and medically necessary follow-up care detected at this visit provided by a participating Plan Provider without the need for referral from the Primary Care Physician. Any procedures or treatments must be authorized by the Plan. Subject to applicable co-payment listed in co-payment schedule.

Ophthalmology services when medically necessary.

Osteoporosis shall be covered for medically necessary diagnosis and treatment for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

Ostomy supplies and urinary catheter are covered when medically necessary. Provisions of ostomy and urostomy supplies are limited to a one month supply every 30 days. Items which are not medical supplies or which would be used by the member or a family member for purposes other than ostomy care are not covered.

Pap smears.

Pathologist services, on an inpatient or outpatient basis related to covered services.

Podiatry services, provided by a participating Plan Provider without the need for referral from the Primary Care Physician as set forth in the schedule of benefits. Any procedures or treatments must be authorized by the Plan.

Pre-admission tests, if medically necessary and when ordered by the covered person's primary physician or Health Plan. However, the following conditions shall be met:

1. The tests shall be ordered or approved by the covered person's treating physician; and

2. The tests shall be performed in a facility accepted by the hospital and the Health Plan in place of the same tests which would normally be done while hospital confined.

Prescription drugs are covered when prescribed by a Physician or other Health Care Provider authorized to prescribe drugs within the scope of their license, and are received by the Covered Person. Prescription drugs purchased from a Participating Pharmacy are subject to the following provisions:

The prescription drug Copayments are shown in the Schedule of Benefits, and are printed on the Covered Person's ID card. The Covered Person's ID card must be presented to a Participating Pharmacy each time a prescription is filled or refilled. The Copayment must be paid by the Covered Person each time a prescription is filled or refilled at a Participating Pharmacy. For a 90 day supply of mail or retail maintenance drugs, only two copayments are required. If the prescribing physician or other participating provider authorized to prescribe drugs within the scope of his or her license indicates on the prescription "dispense as written", when a brand name drug is prescribed with no generic equivalent, the member will pay either the preferred or non-preferred brand copayment In addition to the non-preferred brand copayment, for a drug for which there is a generic equivalent, the covered person shall pay the pharmacist 100 percent of the difference between the cost of the generic and the non-preferred brand name prescription drug when it is dispensed at the request of the covered person.

Covered prescription drugs:

A. Include any drug, medicine, medication, or oral contraceptives that, under Federal or state law, may be dispensed only by prescription from a prescribing Health Care Provider or any compounded prescription containing such drug, medicine or medication;

B. Shall be prescribed by a Physician or Health Care Provider authorized to prescribe drugs within the scope of their license for the treatment of a Condition.

C. Shall be dispensed by a Pharmacist;

D. Shall include FDA approved oral contraceptives, including the morning after pill and contraceptive patches;

E. Shall be a generic medication when both a generic and a more expensive brand name drug are available and equally effective;

F. Shall be limited to the lesser of a 31 day retail supply or a 90 day mail or retail supply per prescription for certain maintenance drugs;

G. Shall include prepackaged items such as insulin, syringes, needles, FDA approved glucose strips and tablets, and chemstrip test tapes dispensed for for a 31 day supply or limit of 100 per month, whichever is greater; and

H. Include prescription refills, but will not be covered until at least 85% of the previous prescription has been used by the Covered Person, (based on the dosage schedule prescribed by the Physician);

I. May require prior authorization for certain drug classes due to high costs, inappropriate usage and/or safety issues, including but not limited to:

1. Injectables and biologicals
2. Nutritional Supplements
3. Select antifungal and antiviral agents
4. Select hematology/oncology agents

J. Include injectable drugs and biologicals, such as drugs, vaccines, or antitoxins that are synthesized from living organisms or their products and used as a diagnostic, preventive or therapeutic agent. All injectable drugs and biologicals with the exception of insulin and covered vaccines require prior approval and are covered only if:

1. Such injectables cannot be self-administered and are furnished incidental to a Health Care Provider's covered professional services;
2. They are reasonable and necessary for the diagnosis or treatment of the Covered Illness or Injury for which they are administered according to accepted standards of the JMH Health Plan;
3. They have not been determined by the FDA to be "less-than-effective";
4. The injection is considered the indicated effective method of administration according to the accepted standards of medical practice for the Covered Condition;
5. The frequency, amount, and duration of the course of injectable drug or biological meets accepted standards of medical practice as an appropriate level of care for a specific condition, unless there are extenuating circumstances which justify the need for additional injections;
6. They are a cost-effective alternative for an otherwise Covered Service as determined by the JMH Health Plan and the Covered Person's treating Physician;

When a Health Care Provider gives the Covered Person a subcutaneous, intramuscular, intravenous or intraarterial injection, no additional payment will be made for the administration of the injection. Payment is made separately for the drug or biological injected, but the cost of the other supplies and the administration of the drug or biological is included in the payment for the visit or other services rendered.

K. Include home administered and self-injectable drugs and biologicals such as drugs, vaccines, or antitoxins that are synthesized from living organisms or their products and used as a diagnostic, preventive or therapeutic agent. All injectable drugs and biologicals with the exception of insulin and covered vaccines require prior approval and are covered only if:

1. Injection is considered the indicated effective method of administration for which the drug or biological is prescribed according to accepted standards of medical care for the covered condition;
2. The drug or biological can be safely self-administered based upon accepted standards of medical practice;
3. They are not immunizing agents;
4. They are reasonable and necessary for the specific or effective treatment of the Covered Condition according to accepted standards of medical practice;
5. They have not been determined by the FDA to be "less-than-effective";
6. The frequency, amount and duration of the prescribed course of injectable drug or biologicals meets accepted standards of medical practice as an appropriate level of care for a specific condition, unless there are extenuating circumstances which justify the need for additional injections; and
7. They are a cost-effective alternative for an otherwise Covered Service as determined by the JMH Health Plan and the Covered Person's treating Physician.

No coverage is provided for:

A. Any drug, medicine or medication that is consumed at the place where the prescription is given or that is dispensed by a Health Care Provider;

B. Any portion of a prescription or refill that exceeds a 31-day retail supply or a 90 day mail order supply (if applicable);

C. Prescription refills in excess of the number specified by the prescribing Health Care Provider or a maximum of 6 per prescription, not to exceed one year from the date prescribed;

D. The administration of covered medication unless otherwise covered herein;

E. Prescriptions that are to be taken by or administered to the Covered Person, in whole or in part, while he or she is a patient in a Hospital, Skilled Nursing Facility, Convalescent Hospital, inpatient hospice facility or other facility where drugs are ordinarily provided by the facility on an inpatient basis;

F. Prescriptions that may be properly received without charge under local, state, or federal programs, or paid for by Worker's Compensation;

G. Prescriptions ordered or received in excess of any maximums covered under this benefit, and not covered under any other provision in this Group Plan;

H. Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use." Any experimental drug or drug used for non-FDA approved indication or prescribed for use by a route of administration that is not approved by the FDA even though a charge is made to the Covered Person;

I. Immunizing agents, biological serums or allergy serums, unless otherwise covered herein;

J. Any drug or medicine that is lawfully obtainable without a prescription, with a few exceptions such as insulin; insulin syringes and needles, non-sedating antihistamines, and proton pump inhibitors;

K. Therapeutic devices or appliances, including hypodermic needles/syringes unless otherwise covered herein; support garments, and other non-medical substances, regardless of intended use;

L. Prescriptions filled at a Non-Participating Pharmacy, except for prescriptions required during an emergency;

M. Drugs and medications used for cosmetic purposes.

- Retin-A to treat acne vulgaris, for ages 26 and over will require prior authorization, and will be dispensed based on medical necessity.

N. Anti-obesity, appetite suppressants or weight loss drugs including but not limited to amphetamines, Adipex-P, Meridia, Tenuare, Xenical;

O. Drugs and medications used as smoking deterrents or for smoking cessation including but not limited to Nicorette, Nicotrol, Zyban;

P. Hormone treatment in preparation for sexual reassignment;

Q. Any costs related to the mailing, sending or delivery of prescription drugs.

R. Drugs or medications used for onychomycosis of the fingernails and toenails unless certain conditions are met, including but not limited to diabetes, immunocompromised, or circulatory disorders.

Preventive medical services shall include but are not limited to a periodic health assessment examination performed by the covered person's primary care physician, which may include:

1. A health history;

2. A physical examination;

3. Laboratory tests which include urinalysis for blood, sugar, and acetone, and hemoglobin and hematocrit tests;

4. A stool for occult blood;

5. A tuberculin skin test;

6. Tests for sexually transmitted diseases;

7. Vision screening; and

8. Hearing screening.

For women, this examination may include a mammogram or a gynecological exam that also includes a manual breast exam, a pelvic exam, and a pap smear. For men, this examination may include a prostate gland screening.

This shall not include exams required for travel, or those needed for school, employment, insurance, or governmental licensing, unless the service is within the scope of, and coinciding with, the periodic health assessment exam. Only one exam per calendar year is allowed.

Orthotic Appliances limited to custom-made leg, arm, back and neck braces when related to a surgical procedure or when used in an attempt to avoid surgery and when necessary to carry out normal activities of daily living, excluding sports activities. Coverage includes the initial purchase, fitting or adjustment. Replacements are covered only when Medically Necessary due to growth or change in bodily configuration. This includes shoe orthotics when attached to a brace. For all other shoe orthotics, only the initial pair is covered with an order from a participating provider. Covered orthotics also include thoracic-lumbar-sacral-orthosis (TLSO) braces, lumbar-sacral-orthosis (LSO) braces, knee ankle foot orthosis (KAFO) braces, knee orthosis (KO) braces, and ankle foot orthosis (AFO) braces, and hand or wrist splints

for carpal tunnel syndrome. All other prosthetic/orthotic devices are excluded. Refer to your Benefit Summary for any Co-payments or Limitations.

Prosthetic Devices including artificial limbs, artificial joints, and ocular prostheses. Coverage includes the initial purchase, fitting, or adjustment. Replacement is covered only when Medically Necessary due to growth or a change in bodily configuration. The initial prosthetic device following a covered mastectomy is also covered. Replacement of an intraocular lens is covered only if there is a change in prescription that cannot be accommodated by eyeglasses. Prosthetic devices for Deluxe, Myo-electric and electronic prosthetic devices, and any other prosthetic devices are not covered. Refer to your Benefit Summary for any Co-payments or Limitations.

Radiologist services, on an inpatient or outpatient basis for covered services.

Rehabilitative services, includes medically necessary rehabilitative services for short-term physical, occupational, and/or speech therapy. Services are limited to acute conditions resulting from injury or an acute episode of illness only when determined by the treating physician and the JMH Health Plan that maximum medical improvement in the covered person's condition is expected within a 60 day time period from the first date of treatment. Therapy services are limited to a two consecutive calendar month period of treatment per episode of illness or injury per lifetime, Long term physical, occupational, speech or other rehabilitation therapy or treatment of chronic conditions including those that are congenital (except in the case of cleft palate) are not covered. Maintenance therapy programs are not covered. Short-term speech therapy will be covered only for the following conditions:

1. Speech problems following a stroke (cerebrovascular accident).
2. Altered speech patterns following neurological brain surgery previously authorized by the Plan.
3. Speech problems resulting from trauma
4. Speech problems resulting from acute conditions leading to hearing impairment
5. Other surgical procedures previously authorized by the Health Plan leading to significant changes in speech patterns

Refer to your Benefit Summary for any Co-payments or Limitations.

Request for second medical opinion

JMH Health Plan does not limit second medical opinions as long as they are obtained through our participating providers. Each Covered Person is entitled to request a second medical opinion by a Physician in any instance in which the subscriber disputes the organization's or the physician's opinion of the appropriateness or necessity of surgical procedures or is subject to a serious illness or injury.

A member with the Open Access Plan, may obtain a second medical opinion from any physician who is within JMH Health Plan's Network. If the member chooses a participating physician to obtain the second medical opinion, there is no prior authorization requirement, and he or she only pays the applicable co-payment or deductible and co-insurance. To obtain second medical opinion from a non-participating provider, the member is allowed three visits per year, with prior authorization, and the member is responsible for 40% of the amount of usual, customary and reasonable charges associated with the consultation.

A member without the Open access plan, requires authorization to obtain a second medical opinion to see participating and non-participating providers, If the member chooses a participating physician to obtain second medical opinion, he or she only pays the applicable co-payment or deductible and co- insurance. To obtain second medical opinion through a non-participating provider, the member is allowed three visits per year, and is responsible for 40% of the amount of usual, customary and reasonable charges associated with the consultation.

If the member requires any tests to render the second medical opinion, they must be arranged by JMH Health Plan, and performed by participating providers. Once a second medical opinion has been rendered, JMH Health Plan shall review and determine the Health Plan's obligations under the Contract and that judgment is controlling. Any treatment the member obtains that is not authorized by JMH Health Plan shall

be at the Member's expense.

Furthermore, second surgical opinions and consultations from a Physician who is listed in the Plan's directory or any Physician located in the same geographical service area after a Covered Person has received a recommendation to have surgery includes the physical examination, laboratory work and x-rays not previously performed by the original Physician. The consulting physician must not be affiliated in practice with the surgeon who first recommended surgery.

The Plan will cover the second surgical opinion services for a Covered Person in obtaining a second surgical opinion, after he or she has received a recommendation to have elective surgery which is covered under this contract, if in addition to the conditions listed above; the following conditions are also met:

1. The consulting Physician must personally examine the Covered Person and the Plan and the Covered Person's Primary Care Physician must receive a copy of the written opinion; and

2. The consulting physician must not perform the surgery to correct the Condition for which the original recommendation was given.

Respiratory therapy, including the services of respiratory or inhalation therapists and oxygen.

Skilled nursing facility services shall be covered only if the covered person's treating physician approves a written plan of treatment submitted by a physician and only if the covered person's treating physician and the Health Plan agrees that such skilled level services shall be provided in lieu of hospitalization or continued hospitalization and shall be subject to the following:

1. The covered person's treating physician certifies the need for the skilled nursing facility and the covered person receives skilled nursing care or services on a daily basis;

2. The transfer to the skilled nursing facility shall be because the covered person requires skilled care for a condition (or related condition) which was treated in the hospital;

3. The covered person shall be admitted to the skilled nursing facility immediately following discharge from the hospital;

4. Services and supplies are limited to 60 days of confinement per calendar year and may include: room and board; respiratory therapy (e.g., oxygen); drugs and medicines administered while an inpatient; intravenous solutions; dressings, including ordinary casts; anesthetics and their administration; transfusion supplies and equipment; diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG)); chemotherapy treatment for proven malignant disease; and other medically necessary services and supplies; and

5. Services shall be skilled level services, and shall be ordered by and provided under the direction of a physician.

If a Covered Person is a resident of a continuing care facility or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, the Covered Person's PCP (if applicable) must refer the Covered Person to that facility's skilled nursing unit or assisted living facility if requested by the Covered Person, agreed to by the facility and subject to final authorization by the Health Plan. The facility must meet all guidelines established by the Health Plan related to quality of care, utilization, referral authorization, risk assumption, use of the Health Plan's provider network, and other criteria applicable to participating providers for the same services and supplies. If the request for referral or authorization is denied, the Covered Person may use the grievance process described in the Grievance Procedure section of the Certificate of Coverage.

Sterilization, limited to tubal ligations and vasectomies.

Surgical procedures, performed on an inpatient or outpatient basis.

Transplantation of a covered tissue and organ transplant, as defined in this section, if approved by the Health Plan, and if performed at a facility approved by the Health Plan subject to the conditions and limitations described in this section and if in accordance with generally accepted professional medical standards and not experimental or investigational.

Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. The Health Plan shall pay benefits only for services, care and treatment received for or in connection with the approved transplantation of the following human tissue or organs: Cornea, Heart, Heart/lung, Whole single lung or whole bilateral lung, Liver, Kidney, Kidney/pancreas, and Bone marrow.

Bone Marrow Transplant, as defined in the Glossary section, which is specifically listed in Rule 59B-12.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. The Plan will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for the Covered Person and will be subject to the same limitations and exclusions as would be applicable to the Covered Person. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified though the National Bone Marrow Donor Program. As used in this Health Plan, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient to restore normal hematological and immunological functions following ablative or nonablative therapy with a curative or life – prolonging intent. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

For a transplant procedure to be considered approved for this transplant benefit, authorization from the Health Plan shall be required in advance of the procedure. The covered person's treating physician shall notify the Health Plan in advance of the covered person's initial evaluation for the procedure in order for the Health Plan to determine if the transplant services shall be covered. For approval of the transplant itself, the Health Plan shall be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval shall be based on written criteria and procedures established by the Health Plan. The transplant procedure shall be performed in a facility that has been authorized by the Health Plan. If authorization is not given, benefits shall not be provided for the transplant procedure.

No benefit shall be payable for or in connection with a transplant if:

1. The organ involved is not listed in this section;

2. The Health Plan is not contacted for authorization prior to referral for transplant evaluation of the procedure;

3. The Health Plan does not approve coverage for the procedure;

4. Expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received;

5. The expense relates to the transplantation of any non-human organ or tissue;

6. The service or supply is in connection with the implant of an artificial organ, including the implant of the artificial organ;

7. The organ is sold rather than donated to the covered person;

8. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Health Plan except in the case of the donor costs for bone marrow transplants; or

9. A denied transplant is performed; this includes follow-up care, immunosuppressive drugs, and complications of such transplant.

The following services and supplies shall not be covered:

1. Artificial heart devices used as a bridge to transplant;

2. Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use; and

3. Any service or supply in connection with identification of a donor from a local, state, or national listing with the exception of bone marrow.

Once the transplant procedure is approved, the Health Plan shall advise the covered person's treating physician of those facilities that have been authorized for the type of transplant procedure involved. Benefits shall be payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in a facility that has been licensed as a transplant facility.

For approved transplant procedures, and all related complications, the Health Plan shall cover only the following services:

1. Hospital expenses and medical expenses shall be paid under the hospital services benefit and medical services benefit in this Health Plan, in accordance with the same terms and conditions as the Health Plan shall pay benefits for care and treatment of any other covered condition; and

2. Organ acquisition and donor costs for bone marrow transplants.

Wigs, are limited to a lifetime maximum of $300 when related to restoration after cancer or brain tumor treatment.

FOLLOWING COVERAGE ACCESS RULES

If covered persons do not follow the coverage access rules described in this section, the covered person risks having services and supplies received not covered by this Health Plan. In such a circumstance, the covered person would be responsible for reimbursing the Health Plan for the reasonable cost of the services rendered.

Covered persons shall remember that services that are provided or received without having been prescribed, directed or authorized in advance by the covered person's treating physician or Health Plan, or if the service is beyond the scope of practice authorized for that health care provider under state law, except in cases of emergency care as described in this plan, are not covered unless such services otherwise have been expressly authorized under the terms of this Health Plan. Except for emergency care services, all services shall be received from participating providers on referral from the covered person's primary care physician or Health Plan.

Also, covered persons shall understand that services that, in the Health Plan's opinion, are not medically necessary shall not be covered. The ordering of a service by a physician, whether participating or non-participating, or when expressly authorized by the primary care physician, does not in itself make such service medically necessary or a covered service.

GENERAL EXCLUSIONS

Acupuncture services.

Arch supports, orthopedic shoes, sneakers, or support hose, or similar type devices/appliances regardless of intended use.

Autopsy or postmortem examination services, unless specifically requested by the Health Plan.

Biofeedback services, and other forms of self-care or self-help training and any related diagnostic testing, hypnotherapy, meditation, mind expansion, cognitive therapy, sleep therapy, sex therapy, elective psychotherapy such as Gestalt therapy, transactional analysis, transcendental meditation, Z-therapy, and Erhard seminar training (EST).

Complications of non-covered services, including the diagnosis or treatment of any condition which arises as a complication of a non-covered service (e.g., services or supplies to treat a complication of cosmetic surgery shall not be covered under this Health Plan).

Cosmetic surgery (plastic and reconstructive surgery), and any other service and supply to improve the covered person's appearance or self-perception. Also excluded are surgical excision or reformation of any sagging skin of any part of the body including but not limited to: the eyelids, face, neck, abdomen, arms, legs, or buttocks; any services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body, including but not limited to: the face, lips, jaw, chin, nose, ears, breasts, or genitals (including circumcision, except newborns for up to one year from date of birth); procedures or supplies to correct baldness or the appearance of skin (wrinkling)including but not limited to: hair transplantation, chemical face peels or abrasion of the skin, electrolysis, depilation, removal of tattooing; or any other surgical or non surgical procedures which are primarily for cosmetic purposes or to create body symmetry.

Costs incurred by the Health Plan, related to:

1. Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy; and

2. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Custodial care, including any service or supply of a custodial nature primarily intended to assist the covered person in the activities of daily living. This includes rest homes (facilities), nursing homes, skilled nursing facility, home health aides (sitters), home mothers, domestic maid services, and respite care.

Dental care for any condition except:
1. When such services are for the treatment of trauma related fractures of the jaw or facial bones or for the treatment of tumors;
2. Reconstructive jaw surgery for the treatment of deformities that are present and apparent at birth;
3. Full mouth extractions when required before radiation therapy; or
4. Treatment following injury to sound natural teeth started within six months of the accident.

Dental implants for any condition.

Dietary regimens, treatments, food, food substitutes, vitamins or exercise programs for reducing or controlling weight.

Durable medical equipment, that are not covered include but are not limited to those that are listed below:
1. Bed Related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses, and posturepedic mattresses
2. Bath Related Items: bath lifts, non-portable whirlpools, bathtub rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas
3. Chairs, Lifts, and Standing Devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer) auto tilt chairs.

4. Fixtures to Real Property: ceiling lifts and wheelchair ramps
5. Car/Van Modifications
6. Air Quality Items: room humidifiers, vaporizers, air purifiers, and electrostatic machines
7. Blood/Injection Related Items: blood pressure cuffs, centrifuges, nova pens, and needleless injectors
8. Other Equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic controlled therapy units, diathermy machines, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors\enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, portable whirlpool pumps, hot tubs, Jacuzzis, swimming pools, and exercise equipment of any kind.

Experimental or investigational treatment, as defined in the glossary.

Elective care, routine care, or care other than medically necessary emergency care including services for a normal pregnancy and delivery outside the service area, unless in the case of pregnancy and delivery, the need for such services was not, and reasonably could not have been, anticipated before leaving the service area.

Eye care, including:

1. The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the covered benefits section;

2. Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error; and

3. Training or orthoptics, including eye exercises.

Family planning services, except as specified on page 31 of this Handbook.

Family maintenance expenses for out of area emergency or elective care.

Foot care (routine), including any service or supply in connection with foot care in the absence of disease, injury or accident. This exclusion includes, but is not limited to, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, or trimming of toenails, unless determined by the Health Plan to be medically necessary.

Gene Testing. except as specified in the covered benefits section.

Gene Therapy. except as specified in the covered benefits section.

Genetic Counseling. except as specified in the covered benefits section.

Hearing aids, (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers and cochlear implants; however, hearing tests shall be a covered service when associated with covered ear surgery.

Hypnotism, medical hypnotherapy or hypnotic anesthesia.

Immunizations and physical examinations, when required for travel, or when needed for school, employment, insurance, or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.

Infertility treatment and supplies, including treatment of infertility, diagnostic procedures to correct the cause or reason for infertility or inability to achieve conception. This includes artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.

Injectables, biological serum, blood and blood plasma, except as specified under the Prescription Drug Program.

Lactation Consultations.

Mandibular and Maxillary Osteotomies, except Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

Massage therapy.

Military service-connected medical care, for which the covered person is legally entitled to service from military or government facilities, and for which such facilities are reasonably accessible to the covered person.

Non-prescription drugs and supplies, including any non-prescription medicine, remedy, biological product, pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, health foods, or blood pressure kits except as specifically provided for in the covered benefits section under prescription drugs.

Obesity and weight reduction treatment, including surgical operations and medical procedures for the treatment of morbid obesity, such as gastric stapling, gastric bypass, and gastric bubbles and any related evaluations or diagnostic tests.

Orthomolecular therapy, including nutrients, vitamins, and food supplements.

Personal comfort, hygiene or convenience items, including services and supplies deemed to be not medically necessary by the Health Plan and not directly related to the care of the covered person, including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than medically necessary ambulance services that are specifically provided for in the covered benefits section, motel/hotel accommodations, air conditioners, humidifiers, dehumidifiers, air purifiers or filters, or physical fitness equipment.

Private Duty Nursing Care.

Prosthetic Devices, including myoelectric prostheses peripheral nerve stimulators; external and internal power enhancements or power controls for prosthetic limbs and terminal devices; or any other electronic prosthetic device.

Removal of warts, moles, skin tags, lipomas, keloids, scars, and other benign skin lesions, even with a recommendation or prescription by a physician, unless the JMH Health Plan determines that there is sufficient justification for removal.

Reversal of voluntary, surgically-induced sterility, including the reversal of tubal ligations and vasectomies.

Services or supplies, that are:

1. Determined not to be medically necessary;

2. Not specifically listed in the covered benefits section unless such services are specifically required to be covered by state or federal law. This Health Plan shall provide coverage on a primary or secondary basis as required by state or federal law;

3. Court ordered care or treatment, unless otherwise covered in this Health Plan;

4. For the treatment of a condition resulting from:

a. War or an act of war, whether declared or not;

b. Participation in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony;

c. Engaging in an illegal occupation;

d. Services in the armed forces; or

e. Intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the covered person.

f. Being under the influence of alcohol or any narcotic unless taken on the specific advice of a Physician.

5. Received prior to a covered person's effective date or received on or after the date a covered person's coverage terminates under this Health Plan, unless coverage is extended in accordance with the extension of benefits provision in the administrative provisions section;

6. Provided by a physician or other health care provider who normally resides in the covered person's home;

7. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;

8. Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change;

9. Supplied at no charge; or

10. Determined by the Health Plan not to be the most cost-effective setting, procedure, or treatment.

Sexual reassignment, reproduction or modification services, including hormone therapy, intersex surgery, sexual deviations and disorders, psychosexual dysfunctions, testicular prosthesis, genetic tests to determine paternity or sex of a child, or the insertion of penile prosthesis except when necessary in the treatment of organic impotence resulting from diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, postprostatectomy, postpriapism, and epispaidas and exstrophy.

Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs and Nicorette gum or patch.

Termination of pregnancy unless deemed Medically Necessary by the Medical Director, subject to applicable state and federal laws.

Temporomandibular joint (TMJ) dysfunction, including services related to the diagnosis or treatment of TMJ except as described in the covered services section and when medically necessary.

Training and educational programs, including programs primarily for pain management, or vocational rehabilitation unless specifically provided by law.

Transfusion, autologous.

Transportation services, that is non-emergency transportation between institutional care facilities, or to and from the covered person's residence.

Volunteer services, or services which would normally be provided free of charge to a covered person.

Weight control/loss programs, including but not limited to, food supplements, appetite suppressants, dietary regimens or treatments, exercise programs, or equipment.

Wigs/ Cranial Prosthesis unless related to restoration after cancer or brain tumor treatment (limited to a lifetime maximum of $300).

Work related condition services to the extent the Covered Service is paid by Workers' Compensation.

GLOSSARY

ACCIDENT shall mean accidental bodily injury sustained by the covered person which results in and is the direct cause of medical expenses independent of illness.

ACCIDENTAL DENTAL INJURY shall mean an injury to the mouth or structures within the oral cavity, including teeth, caused by a sudden unintentional, and unexpected event or force.

AMBULANCE shall mean any private or publicly owned land, air, or water vehicle licensed pursuant to chapter 401, part III, Florida Statutes, or for services rendered outside Florida other states' applicable laws, that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, air, land, or water transportation of persons who are in need of medical or surgical attention.

AMBULATORY SURGICAL CENTER shall mean a facility licensed pursuant to chapter 395, Florida Statutes, or for services rendered outside Florida other states' applicable laws, the primary purpose of which is to provide elective surgical care to a patient, admitted to and discharged from such facility within the same working day, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center.

BIRTH CENTER shall mean any facility, institution, or place, licensed pursuant to chapter 383, Florida Statutes, or for services rendered outside Florida other states' applicable laws, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low risk pregnancy.

CALENDAR YEAR shall mean a period of one year which starts on January 1 and ends December 31.

CONDITION shall mean any disease, illness, injury, bodily dysfunction, pregnancy, or mental or nervous disorder of a covered person. For any preventive care benefits provided in this Health Plan, condition shall include the prevention of sickness.

CONFINEMENT shall mean an approved medically necessary covered stay as an inpatient in a hospital that is:

1. Due to a condition; and

2. Authorized by a licensed medical health care provider with admission privileges.

Each "day" of confinement includes an overnight stay for which a charge is customarily made.

COPAYMENT shall mean those amounts payable by the covered person, at the time of service, as specifically set forth in the schedule of member copayments. The copayment shall be expressed as a dollar amount.

COVERED PERSON shall mean eligible employees, retirees, surviving spouses, COBRA participants, or any eligible dependents included for coverage under this Health Plan. Eligibility requirements are specified in the administrative provisions section.

COVERED SERVICES OR SUPPLIES shall mean any of the following:

1. Medical services, supplies or equipment which are medically necessary and not otherwise excluded by the Health Plan; and
2. Child health supervision services (well child care).

CUSTODIAL CARE shall mean care which shall not require skilled nursing care or rehabilitation services and is designed solely to assist the covered person with the activities of daily living, such as: help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine.

DENTAL CARE shall mean dental x-rays, examinations and treatment of the teeth or any services, supplies or charges directly related to (i) the care, filling, removal or replacement of teeth, or (ii) the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth, that are customarily provided by dentists (including orthodontics reconstructive jaw surgery, casts, splints, and services for dental malocclusion).

ELECTIVE ADMISSION shall mean a hospital admission which is not of an urgent or emergency nature and can be scheduled in advance and at a time which is convenient for the covered person and the covered person's physician without risking the covered person's well being.

ELECTIVE SURGERY shall mean surgery of a non-emergency nature in which the covered person can elect when, or if, surgery can be done.

EMERGENCY MEDICAL CONDITION shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a. Serious jeopardy to the health of a patient, including a pregnant woman or fetus.
b. Serious impairment of bodily functions.
c. Serious dysfunction to any bodily organ or part

With Respect to a pregnant woman:

a. that there is inadequate time to effect a safe transfer to another hospital prior to delivery;
b. that the transfer may pose a threat to the health and safety of the patient or fetus; or
c. that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

EMERGENCY SERVICES AND CARE shall mean medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if any emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT shall mean any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined by the Division for State Group Insurance:

1. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the or other appropriate government entity, and approval for marketing has not, in fact, been given at the time such is furnished to the covered person;

2. Such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I, or II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question;

3. Reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question;

4. Such evaluation, treatment, therapy, or device has not been proven safe and effective for the treatment of the condition in question, as evidenced in the most recently published medical literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

5. There is no consensus among practicing physicians that the treatment, therapy or device is safe or effective for the treatment in question; or

6. Such evaluation, treatment, therapy, or device is not the standard treatment, therapy or device utilized by practicing physicians in treating other patients with the same or similar condition.

Reliable evidence shall mean:

1. Reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;

2. Published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;

3. The written protocol or protocols relied upon by the treating physician or institution or the protocols of another physician or institution studying substantially the same evaluation, treatment, therapy, or device;

4. The written informed consent used by the treating physician or institution or by another physician or institution studying substantially the same evaluation, treatment, therapy, or device; or

5. The records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy or device for the condition in question

FULL-TIME POSITION means any position authorized for the normally established work period as set forth in the Master Employer Application.

GROUP EFFECTIVE DATE shall mean the effective date of the contract with the Health Plan.

HEALTH CARE PROVIDER OR PROVIDERS shall mean comprehensive outpatient rehabilitative facilities, dialysis centers, durable medical equipment suppliers, and the following health care professionals and facilities licensed pursuant to the noted chapter in Florida Statutes, or for services rendered outside Florida other states' applicable laws: advanced registered nurse practitioners (464), ambulance (401), ambulatory surgical centers (395), anesthesiologists (458), audiologists (468), birthing centers (383), certified nurse midwives (464), certified registered nurse anesthetists (464), chiropractors (460), clinical laboratories (483), clinical social workers (491), dentists (466), home health agencies (400), hospice (400), hospitals (395), lithotripsy facilities (395), marriage and family therapists (491), mental health counselors (491), midwives (467), nurse clinicians (464), nurse practitioners (464), nurses (464), opticians (484), optometrists (463), oral surgeons (458), osteopaths (459), pharmacies (465), pharmacists (465), physical therapists (486), physicians (458), physician assistants (458, 459, 460), podiatrists (461), psychologists (490), rehabilitation facilities (395), residential treatment facilities (394), respiratory therapists (468), skilled nursing facilities (400), speech-language pathologists (468), specialty facilities (394), substance abuse facilities (394).

HOME HEALTH AIDE shall mean a person certified by an accredited junior college or vocational technical school as having completed an approved course of study.

HOME HEALTH AGENCY shall mean an institution or agency licensed pursuant to chapter 408, part IV, Florida Statutes, or for services rendered outside Florida other states' applicable laws, which provides approved services for people who are confined and convalescing at home in lieu of the hospital. A home health agency may operate independently or as part of a hospital.

HOSPICE shall mean an autonomous, centrally administered, nurse-coordinated program licensed pursuant to chapter 400, part VI, Florida Statutes, or for services rendered outside Florida other states' applicable laws, which provides a continuum of home, outpatient and inpatient care for a terminally ill covered person and members of the covered person's family. It employs an inter-disciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

HOSPITAL shall mean a facility licensed pursuant to chapter 395, Florida Statutes, or for services rendered outside Florida other states' applicable laws, engaged in providing medical care and treatment to a patient as a result of illness, accident or mental or nervous disorder on an inpatient or outpatient basis at the patient's expense and which fully meets all the following tests:

1. It is a hospital accredited by the Joint Commission on the Accreditation of Hospitals or the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities;

2. It maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of patients under the supervision of a staff of fully licensed physicians. However, no claim for payment of treatment, care or services shall be denied because a hospital lacks major surgical facilities or is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability; and

3. It continuously provides 24 hours a day nursing service by or under the supervision of registered graduate nurses.

The term hospital shall not include a specialty or residential facility; nor shall it include a U.S. Government hospital or any other hospital operated by a governmental unit, unless a charge is made by such hospital that the patient is legally required to pay without regard to the existence of insurance.

ILLNESS shall mean physical sickness or disease, pregnancy, bodily injury, or congenital anomaly.

INJURY shall mean an accidental bodily harm that:

1. Is caused by a sudden and unexpected event or force;

2. Is sustained while the covered person's coverage is in force; and

3. Results in and is the direct cause of medical expenses independent of illness.

INPATIENT shall mean a covered person who has been admitted upon the orders of a physician as a bed patient for medically necessary services and/or treatment in a hospital or other covered facility.

INTENSIVE CARE UNIT shall mean a specialized area in a hospital where an acutely ill, medical or surgical inpatient receives intensive care or treatment. Included in the hospital's charge for such units are the services of specially trained professional staff and nurses, supplies, the use of any and all equipment and the patient's board. When utilized, a coronary care unit shall also be defined as an intensive care unit.

INTER-DISCIPLINARY TEAM shall mean the working unit composed by the integration of the various helping professionals and lay persons providing hospice care. Such team shall, at a minimum, consist of a physician licensed pursuant to chapter 458 or 459, Florida Statutes, or for services rendered outside Florida other states' applicable laws, a nurse licensed pursuant to chapter 464, Florida Statutes, or for services rendered outside Florida other states' applicable laws, a social worker licensed pursuant to chapter 491, Florida Statutes, or for services rendered outside Florida other states' applicable laws, a member of the clergy or counselor, and volunteers. Such team shall be primarily concerned with controlling the physical, sociological and psychological symptoms of degenerative disease.

MANIPULATIVE SERVICES shall mean a term of physical medicine involving the skillful and trained use of the hands to treat diseases or symptoms resulting from misalignment of the spine. Manipulative services do not include massage therapy.

MEDICAL SUPPLIES OR EQUIPMENT shall mean supplies or equipment that shall be:

1. Ordered by a physician;

2. Of no further use when medical need ends;

3. Usable only by the covered person;

4. Not primarily for the covered person's comfort or hygiene;

5. Not for environmental control;
6. Not for exercise; and

7. Manufactured specifically for medical use.

MEDICALLY NECESSARY shall mean a medical service or supply that is required for the identification, treatment, or management of a Condition is Medically necessary if, in the opinion of the Health Plan, it is: (1) consistent with the symptom, diagnosis, and treatment of the Insured's Condition; (2) widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence; (3) universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment; (4) not Experimental or Investigation; (5) not for cosmetic purposes; (6) not primarily for the convenience of the Insured, the Insured's family, the Physician, or other Provider, and (7) the most appropriate level of service, care or supply which can safely be provided to the Insured. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Insured in an alternative setting.

MEDICARE shall mean the health insurance programs under Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

MEDICARE I shall mean individual coverage for retirees or surviving spouses who are eligible for Medicare.

MEDICARE II shall mean family coverage for retirees or surviving spouses with one or more eligible dependents where at least one, but not all, covered persons are eligible for Medicare.

MEDICARE III shall mean family coverage for retirees and their spouses only, both of whom are eligible for Medicare.

MENTAL AND NERVOUS DISORDER shall mean any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder. Examples shall include, but are not limited to, attention deficit hyperactivity, bulimia, anorexia-nervosa, bipolar affective disorder, schizophrenia, anxiety, depression, and Tourette's disorder.

MENTAL HEALTH PROVIDERS shall mean psychiatrists licensed pursuant to chapter 458 and 459, Florida Statutes, or for services rendered outside Florida other states' applicable laws; psychologists licensed pursuant to chapter 490, Florida Statutes, or for services rendered outside Florida other states' applicable laws; clinical social workers, marriage and family therapists, and mental health counselors licensed pursuant to chapter 491, Florida Statutes, or for services rendered outside Florida other states' applicable laws; medical doctors licensed pursuant to chapter 458, Florida Statutes, or for services rendered outside Florida other states' applicable laws; and doctors of osteopathy licensed pursuant to chapter 459, Florida Statutes, or for services rendered outside Florida other states' applicable laws.

MIDWIFE shall mean a person licensed pursuant to chapter 467, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to practice midwifery including a certified nurse midwife licensed pursuant to chapter 464, Florida Statutes, or for services rendered outside Florida other states' applicable laws.

NON-PARTICIPATING HOSPITAL shall mean a hospital which has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NON-PARTICIPATING PHARMACY shall mean a pharmacy that has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NON-PARTICIPATING PHYSICIAN shall mean a physician who has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NON-PARTICIPATING PROVIDER shall mean a hospital, a physician, or a health care provider who has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NURSING SERVICES shall mean services that are provided by an advanced registered nurse practitioner (A.R.N.P.), registered nurse (R.N.), or a licensed practical nurse (L.P.N.), who is licensed pursuant to chapter 464, Florida Statutes and:

1. Acting within the scope of that person's license; or

2. Authorized by a physician; and

3. Not a member of the covered person's immediate family.

OUTPATIENT shall mean a patient who is receiving medically necessary care or treatment ordered by a physician and who is not an inpatient.

OUTPATIENT HEALTH CARE FACILITY shall mean a licensed facility other than a physician's, physical therapist's, or midwife's office, which is engaged in providing medically necessary outpatient services for the treatment of a covered illness or accident.

PALLIATIVE CARE shall mean the reduction or abatement of pain and other troubling symptoms by appropriate coordination of all elements of the inter-disciplinary team required to achieve needed relief of distress.

PARTICIPATING HOSPITAL shall mean a hospital which has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PARTICIPATING PHARMACY shall mean a pharmacy which has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PARTICIPATING PHYSICIAN shall mean a physician who has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PARTICIPATING PROVIDER shall mean a hospital, a physician, or a health care provider who has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PHARMACIST shall mean a person who is licensed pursuant to chapter 465, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

PHARMACY shall mean an establishment licensed pursuant to chapter 465, Florida Statutes, or for services rendered outside Florida other states' applicable laws, where prescription medications are dispensed by a pharmacist.

PHYSICAL THERAPIST shall mean a person who is duly registered or licensed pursuant to chapter 486, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to engage in physical therapy practice.

PHYSICIAN shall mean a person properly licensed to practice medicine pursuant to Florida Statutes, as noted, or for services rendered outside Florida other states' applicable laws, including:

1. A doctor of medicine (458) or doctor of osteopathy (459);

2. A licensed dentist (466) who performs specific surgical or non-dental procedures covered by the Health Plan, or who renders services due to injuries resulting from accidents, provided such procedures or services are within the scope of the dentist's professional license;

3. A licensed optometrist (463) who performs procedures covered by the Health Plan provided such procedures are within the scope of the optometrist's professional license;

4. A licensed podiatrist (461) who performs procedures covered by the Health Plan provided such procedures are within the scope of the podiatrist's professional license;

5. A licensed psychologist (section 490.003(3)) when providing a medically necessary covered service; or

6. A licensed chiropractor (460) who performs procedures covered by the Health Plan provided such procedures are within the scope of the chiropractor's professional license.

7. A registered nurse anesthetist section (464) who provides anesthesia coverage, benefits, or services covered by the Health Plan provided such services are within the scope of the registered nurse anesthetist's professional license.

PLAN shall mean the Subscribing Group Insurance Program.

POLICY shall mean the written document which describes the covered benefits provided Subscribing Group Insurance Program.

PRESCRIPTION shall mean a direct order for the preparation of a medication for the benefit of and use by a covered person. This order may be given to the pharmacist verbally or in writing by the physician or other participating provider authorized to prescribe drugs within the scope of his or her license. The medication shall be obtainable only by prescription.

PRESCRIPTION DRUGS shall mean drugs and medicines requiring a written prescription for drugs approved by the United States Food and Drug Administration and dispensed by a licensed pharmacist. Over-the-counter drugs, investigational or experimental drugs, for contraception, drugs used for cosmetic purposes, Nicorette and similar drugs used to deter smoking are not included for coverage even though a physician or other participating provider authorized to prescribe drugs within the scope of his or her license may write a prescription for such.

PRIMARY CARE PHYSICIAN shall mean a participating physician who has been chosen by the covered person to be responsible for providing, prescribing, directing, and authorizing all care and treatment of the covered person.

PRIVATE ROOM shall mean a hospital room with one bed accommodation in which an inpatient receives board and general nursing care included in the hospital's charge for such room.

PROGRESSIVE CARE UNIT shall mean a specialized area in a hospital furnished with appropriate equipment for monitoring and medically supervising inpatients who are no longer considered to be critical or require intensive care or treatment but who have not improved enough to be returned to a routine hospital care environment.

PSYCHIATRIC FACILITY shall mean a facility licensed pursuant to chapter 394, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to provide for the medically necessary care and treatment of mental and nervous disorders. For the purposes of this Health Plan, a psychiatric facility is not a hospital, as defined in this Health Plan.

SEMI-PRIVATE ROOM shall mean a hospital room with two bed accommodations in which an inpatient receives board and general nursing care included in the hospital's charge for such room.

SERVICE AREA means the geographic area in which the Health Plan is authorized to provide health services as approved by the Agency for Health Care Administration. The Health Plan's Service Area is comprised of Dade and Broward counties in the State of Florida.

SICKNESS shall mean a bodily disease for which expenses are incurred while coverage under this Health Plan is in force.

SKILLED NURSING CARE shall mean care which is furnished by, or under the direct supervision of, licensed registered graduate nurses (under the general direction of the physician) to achieve the medically desired result and to ensure the covered person's safety. Skilled nursing care may be the rendering of direct care, when the ability to provide the service requires specialized (professional) training; or observation and assessment of the covered person's medical needs; or supervision of a medical treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired medical results.

SKILLED NURSING FACILITY shall mean an institution licensed pursuant to chapter 400, part I, Florida Statutes, or for services rendered outside Florida other states' applicable laws, or a distinct part of a hospital, primarily engaged in providing the following to inpatients:

1. The treatment shall be given by or under the supervision of a physician;

2. Skilled nursing services shall be given by or under the supervision of a licensed registered graduate nurse;

3. Rehabilitative services shall be given by or under the supervision of licensed physical therapists;

4. It shall not primarily be a place of rest, a nursing home or place of care for senility, drug addiction, alcoholism, mental retardation, psychiatric disorders, chronic brain syndromes or a place for the aged; and

5. Other medically necessary related covered health services.

SPECIALTY INSTITUTION OR RESIDENTIAL FACILITY shall mean a facility licensed pursuant to chapter 394, Florida Statutes, or for services rendered outside Florida other states' applicable laws, which provides an inpatient rehabilitation program for the treatment of persons suffering from alcohol or drug abuse or mental or nervous conditions. Such program shall be accredited by the Joint Commission of the Accreditation of Hospitals (JCAH) and approved by the Department of Health and Rehabilitative Services.

TERMINALLY ILL shall mean a medical prognosis of limited expected survival of one year or less at the time of referral to a hospice program, of a covered person with a chronic, progressive illness which has been designated not curable by the covered person's attending physician.

TREATING PHYSICIAN shall mean the physician responsible for providing primary or specialty care to a covered person on an inpatient or outpatient basis.

WELL-BABY HOSPITAL NURSERY SERVICES shall include those covered services and supplies associated with the care of a healthy newborn child.

JMH HEALTH PLAN
155 SOUTH MIAMI AVENUE
SUITE 110
MIAMI, FL 33130
Telephone: 305-575-3640 or 1-800-721-2993